OREGON HEALTH FUND BOARD – Federal Laws Committee

April 22, 2008 **CCC – Wilsonville Training Center Room 112**
1:00 pm – 5:00 pm (Digitally Recorded) **Wilsonville, Oregon**

MEMBERS PRESENT: **Frank Baumeister, M.D., Chair**
Ellen Gradison, Vice Chair
Chris Bouneff
Michael Huntington, M.D.
Mallen Kear, R.N.
Cheryle Kennedy
Sharon Morris
Nicola Pinson
Thomas Reardon, M.D.

MEMBERS EXCUSED: **Larry Mullins**
Julie James
Mike Bonetto

STAFF PRESENT: **Susan Otter, Policy Analyst**
Barney Speight, Executive Director, OHFB
Judy Morrow, Assistant

STAFF EXCUSED: **Erin Fair, University of Oregon Law Student, OHFB Intern**

ISSUES HEARD:

- **Call to Order**
- **Approval of Agenda and April 8 Meeting Minutes**
- **Committee Discussion**
- **Provider workforce/Training of Health Professionals Panel**
- **Indian Health Service Tribal and Urban Programs Panel**

(Digitally Recorded)

Chair Baumeister I. Call to Order

- There was a quorum.

Chair Baumeister II. Approval of Agenda and April 8 Meeting Minutes (See Exhibit Materials 2)

Motion to approve the minutes for April 8 was seconded. **Motion passed unanimously.**

Chair Baumeister III. Committee Discussion (See Exhibit Materials 3a,b)

ERISA: Initial Draft Findings/Recommendations (exhibit materials 3a)

- Recommendation 1 - It was noted that a bill is being introduced in the U.S. House creating a safe harbor. Staff will locate this bill.
- Recommendation 2 – Discussion on the use of the word "amend," recognizing that, since its inception in 1974, ERISA has never been revised.

- It was related that there is an opinion that the states already have some authority to collect information as long as it doesn't reach a state of burdensomeness.
- Discussion on seeking an ERISA waiver similar to Hawaii's. ERISA waiver possibility is believed to be very low.
- Broad based tax (payroll) of 5% that is being considered by the Finance Committee and ERISA implications were related by Barney Speight. The plan includes offsets for employers providing coverage (Pay-or-play).
- Policy neutrality is needed and state cannot mandate what type of coverage is offered. Amount of employer contribution in Massachusetts is discussed.
- Presentation by Dr. Pat Butler to the Committee on 03/25/08 regarding ERISA is referenced.

- Staff noted that there is background and supportive text to be added to the recommendation relating a study by the National Association of Insurance Commissioner's (NAIC) in which 2/3 of the states said that ERISA was a barrier to health reform efforts. Four recommendations, similar to this Committees', from the NAIC report are:
  1) Amend ERISA to clarify that states may require self-insured plans to submit data;
  2) Amend ERISA to clarify that pay-or-play assessments are not pre-empted by federal law;
  3) Grant the Secretary of Labor the authority to grant waivers from ERISA for comprehensive health reform proposals; and
  4) Create a federal grant program to provide grants to states pursuing new and innovative reform ideas.
- Suggestion to incorporate NAIC report recommendations. Staff will look at the suitability of NAIC recommendation 3, which grants the Secretary of Labor ERISA grant waiver authority, for consideration by this committee.
- General agreement that Committee is comfortable with proposed recommendations.

Federal Tax Code: Initial Draft Findings/Recommendations (exhibit materials 3a)

- Discussion that, under an individual mandate, there should be some equitable federal tax treatment for those in the individual market. State can offer credit, but most relief would come from federal tax benefits.
- Suggestion that Committee recommendations should be cognizant of other discussions at federal level of changing current tax credit for health insurance and that Committee recommendations should not counter these changes, but run parallel.
  - Caveat to legislature connecting federal tax with Oregon tax
- General agreement that Committee is comfortable with proposed recommendations.

HIPAA: INITIAL DRAFT FINDINGS/RECOMMENDATIONS (See Exhibit Material 3b)

- Discussion that HIPAA is not a legal barrier but may be an operational barrier due to restrictive interpretations by various entities. Suggestion to add a recommendation for educational component.
  - Suggestion for greater specificity in finding.

EMTALA: INITIAL DRAFT FINDINGS/RECOMMENDATIONS (See Exhibit Material 3b)

- Conflict between EMTALA and Oregon law in relation to mental health treatment from testimony by EMTALA panel on 04/08/08 discussed.
  - No EMTALA recommendation regarding federal policy.
  - Suggestion to include Committee's concern that there exists a weakness in State mental health policy that conflicts with EMTALA.
- Discussion regarding emergency department (ED) testimony from 04/08/08 regarding ED use for primary care during "down times," the lack of facilities for mental health and that use of ED service in these areas reflects a broken system.
- Preventable ED use discussed.

Chair Baumeister **IV. Provider Workforce/Training of Health Professionals Panel (see Exhibit Materials 4a-g)**

Jo Isgrigg, Ph.D., Executive Director, Oregon Healthcare Workforce Institute (OHWI), gave a presentation on "The Federal Government's Role in Healthcare Workforce Development and Distribution." **(See PowerPoint presentation 1).**

- Gave an overview of "Oregon's Provider Picture."
- Provided statistics on Oregon's healthcare workforce, including physicians, physician assistants, dentists, dental hygienists, nurses, and advanced practice nurses.
- Projected trends modeled by the Oregon Employment Department (OED) explained.
- Federal funding budget through the Health Resources and Services Administration (HRSA), which awards scholarships and provides loans, is provided. **(See Exhibit Materials 4b).**
  - HRSA also provides funding for institutions and states through grants, including programs that target minority populations.
  - Noted several programs that are proposed to be cut by the administration.
- Loan repayment programs discussed as a recruiting tool for areas with health professional shortages.
- International Medical Graduates (IMG) through U.S. Immigration policies is discussed.
- The need to collect data to reflect an accurate picture of the existing workforce is related.
  - Related that State Senator Morse of the Subcommittee on Health Care Reform has asked the OHWI to work with licensing boards to gather information. The Oregon Board of Nursing and North Carolina has been a model of workforce data collection starting in the 1970s.

Mark Richardson, M.D., M.Sc.B., M.B.A., Dean of OHSU School of Medicine (PowerPoint presentation 2)

- Presentation focused on physician shortages.
- Massachusetts increase in number of individuals covered without an increase in providers related.
- Addressed reasons for Oregon's declining numbers of physicians including:
  - Aging workforce with half 50+ years old.
  - High malpractice insurance costs.
  - Lower Medicare reimbursement rates.

- Federally capped residency training opportunities.
- Unlike national trends, 50% of OHSU grads have chosen primary care.
- Federal cap of post-MD training positions noted.
- Oregon Medicine (ORMED) Collaborative is described including regional partnering. Funding was not continued by the last legislature but it is hoped that it will be funded at the next legislature.
- ORMED three step proposal is presented. (See slide 14).
- Statistical data on applicants, GME trainees, and percentages of graduates that stay in Oregon is related.
- Federal inequity noted in number of residents allowed under GME cap in western states when compared to U.S. in whole.
- Question asked whether women graduates end up less productive when in workforce than men. Dr. Richardson noted that newly graduated women have similar workforce productivity goals as their male counterparts.
- Strategies, including loan forgiveness programs, discussed.
- Balanced Budget Act of 1996 capped GME slots for all existing programs, but new training programs are not capped.
- Discrepancies of roles of physician's assistants and nurse practitioners from state to state are discussed.
- When asked to explain OHSU's high rate of graduates choosing primary care, the school's robust family practice program was noted, but Dr. Richardson added that the careful selection of applicants is another factor.
- Of OHSU's 270 post graduate spots, how many of those residency slots are primary care? Dr. Richardson estimated it was about 40%. If you include OB/GYN, pediatrics, internal medicine and family medicine, then it is a little better than 50%.
- In regards to this committee, are there specific federal laws that need addressing or is it mostly money? Dr. Richardson stated laws regarding GME cap and Medicare payment issue, including the reimbursement of nurse practitioners vs. physicians.
- IMG requirements, ethical considerations of training in the U.S. vs. other countries and data on returning to practice in the U.S. are discussed.

Chair Baumeister V. Indian Health Service Tribal and Urban Programs Panel

Jim Roberts, Health Policy Analyst for the Northwest Portland Area Indian Health Board and Geoffrey Strommer, Attorney, Hobbs, Straus, Dean and Walker LLC introduced themselves, provided background information and gave a presentation on the "Indian Health System." **(See PowerPoint presentation 3 and Exhibit Materials 5a,b,c,d)**

- Nine federally recognized Oregon Tribes identified.
- Oregon's Urban Indian Program "Native American Rehabilitation Association (NARA)" located in Portland provides services to approximately 7,000 American Indian/Alaskan Native (AI/AN) individuals.
- Examples of "non-beneficiaries" (legal term relating to non-Indians that are eligible for services due to special circumstances) are given.
- Importance of Indian policy to Federal Laws Committee and OHFB:
  - Impact on Indian policy possibly due to changes to federal laws.
  - Importance of Medicare, Medicaid and SCHIP programs related.

    - Oregon policies could be precedent setting and impact Tribes outside of Oregon.
- Federal Trust Responsibility and relationship between U.S. Federal government and Indian Tribes explained.
    - History including the Treaty Clause and Supremacy Clause of the Constitution that gives Congress supremacy over Indian affairs, Federal Trust Responsibility defined through interpretation by the courts (including health care), no inherent rights of States to deal on political level with Tribes, and political relationship between two sovereigns is presented.
    - Historical information on the termination of special relationship with Tribes in the 1940's and 50's described.
    - Self-Determination Era in the 1960's and 70's by President Nixon led to a shift in federal policy that gave Tribes authority over operation of programs. Self-Determination Act of 1975 described. Choice between self-governance and Title I contracts of Tribes related.
    - Presenters will provide staff with a list of Oregon Tribes of self-governance vs. Title I.
    - Indian Health Care Improvement Act (1976) described as key Indian health federal law. This act with Self-Determination Act provided framework for the health care delivery system operating at Tribal level.
    - Medicare, Medicaid, SCHIP, and Medicare Modernization Act related followed by background on IHS.
    - Research indicates that when Tribes assume programs from feds, quality improves while those that remained in the direct service had decreased services and closed down facilities. Attests to the efficiency of Tribal governments in managing health care.
    - Northwest is the originator of many changes in policy.
    - IHS provides outpatient, ambulatory, primary care; inpatient care hospitals; medical specialties, traditional healing; dental and vision care, behavioral health and specialty care services.
        - Portland area does not have Tribal inpatient hospitals. More efficient to purchase care. Tribes in the Portland area are researching establishing an inpatient medical center.
        - Question: Is the model being considered similar to the Anchorage facility? Yes. The Alaskan Native Medical Center, has regional health center that feeds into a tertiary care.
- Data demonstrating significant AI/AN health disparities are presented.
- Per capita funding inequities presented in graph. Funding is number one issue.
- Guiding principles for Medicaid reform discussed.
    - There is no cost to state for programs through Medicaid and SCHIP due to 100% federal match.
    - No cost sharing requirements.
    - Benefit design and loss of benefits as a result of the implementation of the OHP Plus plan, even though there is no cost to state, discussed. Money lost in matching funding.
    - Developing recommendations that will not negatively affect Indian health care.
- Question: Does a Tribal member in Oregon, eligible for Medicaid, have the choice of managed care vs. fee-for-service? Yes. If they do not choose within a certain time period they will automatically be enrolled in a managed care plan.

- Question: Since most Oregon Tribes have Tribal operated health services, do they participate in Medicaid managed care plans or not? Committee Member and Council Chairwoman of the Confederated Tribes of Grand Ronde, Cheryle Kennedy, responded that they do now, but it was difficult process and were disallowed in the beginning.
- Rights to culturally competent care and traditional medicine are stated.
- The unique circumstances related to the Indian Health System (see slide 31), including treatment to non-Indians, are highlighted. It was related that many are community health centers with a 330 designation under HRSA and must provide services to non-Indians.
- Refers to pg. 71 of document by Carol Barbero, Esq. **(See Exhibit Materials 5b)** outlining circumstances.
- Questions and discussion on funding for Tribal members served including Contract Health Services (CHS) program, formula for funding, rationing of care and priorities one and two explained with CHS chronic underfunding stated.
    - To deal with underfunding, some Tribes cost shift money from line items (e.g. mental health, dental health) into CHS program to provide more care through that program but reduces services in the other categories.
- Only Tribes have rights under Indian Self-Determination and Education Assistance Act (ISDEAA), not Urban Indian programs.
- Development of mid-level practitioners, initiated in Alaska, discussed.
    - Dental health aide designed from New Zealand model.

Discussions and Questions

- Are physicians supplied to the IHS through the federal government for a period of time, such as in the military? The IHS recruits through regular process and through the Commission Corp.
- Do you have any relationship to try and arrange for AI/AN individuals who are interested medical school, such as in the Dakotas, to attend and return to serve the Tribal population? Related information regarding the Indian Health Care Improvement Act, Title II, provision for national scholarship funding. There are no slotted positions.
- The role of the Federal Laws Committee in relation to the special role of the Indian Health Services is summarized as an awareness issue to alert other committees of the special relationship with the federal government. This is important to ensure that Committee/Board recommendations do not harm existing programs that have been gained after long struggles. The adverse effects on Tribal health care with changes to the Oregon Health Plan (OHP) were identified. It was noted that some problems have been addressed in SB 878, which would afford Indians on the Standard plan to receive the same benefits as those in the Plus plan. SB 878 passed in 2002 but still has not yet been approved by CMS for implementation.
- The overlooking of the public health role of the IHS by State public health has added to health disparities.
- Clarification that health disparities data presented is national. It was related that Oregon data is similar.
- IHS CHS funding formula of 70% population/30% health status markers within capitated limit is explained.
- There is an opportunity to address the health disparities of the Tribal populations through a benefit design as the federal government will reimburse these health care expenses 100%. However, the

relationship between the Federal government and Indian Tribes must be weighed when considering all recommendations as they have the potential to inadvertently, negatively affect Indian health care.

- Question on services provided to an AI/AN individual who is covered through his employer. IHS will provide care but reimbursement eligibility depends on provider. Barney Speight related Washington State Law that requires IHS providers to be treated as participating providers in any commercial health plan that is serving a Tribal member covered by that plan. This is identified as a possible recommendation for the Board to consider.
- Jim Roberts thanked the Committee and Barney Speight for recognizing the need to include Tribal representation in the committees.
- Differences between other regions illustrated. For example, Alaska and other regions have hospitals and receive IHS funds while Northwest and Great Lakes Tribes do not have hospitals and rely only on CHS funds for some areas of care.
- Summary of eligible reimbursements outlined:
  - Portion of Tribal membership on Medicare if served by IHS does not receive reimbursement, Tribal health units were excluded. If they go outside the system, then it is paid.
  - In Oregon, Medicaid/OHP is reimbursable.
  - If insured through employer, must be an eligible provider. There is an application process to obtain eligibility. Difficulty is experienced with turnover of eligible providers.
  - If uninsured, services are paid through IHS funds.
- Estimates of distribution over the above categories with the uninsured being the greatest percentage.
- Problems include designation as a public health unit and transportation.
- Payment for visit for only one treated condition/day is related.

Chair Baumeister VII. Adjourn

The meeting was adjourned by Chair Baumeister.

Next meeting May 13, 2008.

Submitted By:
Paula Hird

Reviewed By:
Susan Otter

EXHIBIT MATERIALS

1. Draft Agenda for April 22 meeting
2. Federal Law Committee minutes of 04/08/08.
3. Draft Recommendations
   a. ERISA and Federal Tax Code Draft Recommendations
   b. HIPAA and EMTALA Draft Recommendations
4. Provider Workforce
   a. Oregon Health Professionals Shortage Areas (HPSAs): Primary Care Designations Map, Jan. 2008
   b. "Federal Programs to Increase the Supply of Workers in Primary Health Care," Congressional Research Service, April 2008.
   c. "PRIMARY CARE PROFESSIONALS: Recent Supply Trends, Projections, and Valuation Services," GAO Report # GAO—08-472T, Feb. 2008
   d. DHS letter to CMS regarding changes in Graduate Medical Education program
   e. Excerpt from "Oregon Health Care Workforce Needs Assessment 2006," Oregon Employment Department
   f. Excerpts from "Student Completing Healthcare Workforce Studies in Oregon: Supply Trend Analysis, May 2007," Oregon Healthcare Workforce Institute
   g. "Partnerships and Investments in Oregon's Healthcare Workforce: Private and Federal Government Contributions Jan. 2008-March 2007, Oregon Healthcare Workforce Institute
5. Indian Health Service Tribal and Urban Programs
   a. Northwest Portland Indian Health Board Letter to OHFB, January 31, 2008.

   b. "Legal Basis for Special CMS Provisions for American Indians and Alaskan Natives," Carol Barbero, Esq., Hobbs, Straus, Dean and Walker, LLP.
   c. "Health Disparities Challenge Public Health among Native Americans," Jim Roberts and Joshua T. Jones, Northwest Public Health, Fall/Winter 2004.
   d. "HIPAA and Patient Privacy: Tribal Policies as Added means for addressing Indian Health Disparities," S. K. Roels, Esq., American Indian Law Review, Vol. 31 No 1, 2007.
6. Summary of Proposed HB HR 3162 "Champ Act of 2007", section 304, proposing 5% increase in Medicare payments to efficient physicians.
7. Research and follow-up on previous topics:
   a. Summary of April 7 staff meeting with DHS Office of Addictions and Mental Health
   b. 2008 Kinsman Ethics Conference Summary Paper
8. Copies and follow-up documents to April 8 meeting:
   a. "Summary of the Access to Emergency Medical Services Act of 2007," American College of Emergency Physicians
   b. "Vast difference in spending patterns for chronically ill." Kevin Freking, AP Wire, April 8.
   c. "Medicare Finds How Hard it is to Save Money," R. Abelson, New York Times, 04/07/08.
   d. "Oregon ERs lack specialists," J. Rojas-Burke, The Oregonian, 04/09/08.
9. Delivery Systems Committee Progress Report

PRESENTATIONS

1. "The Federal Government's Role in Health Care Workforce Development and Distribution" by Jo Isgrigg, PhD.
2. "Healthcare Reform, Provider Education and a federal regulatory quirk" by Mark Richardson, M.D., MPH.
3. "The Indian Health System" by Jim Roberts and Geoffrey Strommer.

OREGON HEALTH FUND BOARD – Federal Laws Committee

April 8, 2008 **CCC – Wilsonville Training Center Room 112**
1:00 pm – 5:00 pm (Digitally Recorded) **Wilsonville, Oregon**

MEMBERS PRESENT: **Frank Baumeister, M.D., Chair**
Ellen Gradison, Vice Chair
Mike Bonetto (by phone)
Chris Bouneff
Michael Huntington, M.D.
Julie James (by phone)
Mallen Kear, R.N.
Sharon Morris
Nicola Pinson
Cheryle Kennedy
Thomas Reardon, M.D.

MEMBERS EXCUSED: **Larry Mullins**

STAFF PRESENT: **Susan Otter, Policy Analyst**
Barney Speight, Executive Director, OHFB
Erin Fair, University of Oregon Law Student, OHFB Intern
Judy Morrow, Assistant

ISSUES HEARD:

- **Call to Order**
- **Approval of Agenda and March 13 and 25 Meeting Minutes**
- **HIPAA Panel**
- **Committee Discussion: Medicaid**
- **EMTALA Panels**
- **Public Testimony**

(Digitally Recorded)

Chair Baumeister I. Call to Order

- There was a quorum.

Chair Baumeister II. Approval of Agenda and March 13 and 25 Meeting Minutes (See Exhibit Materials 1, 3a,b)

Agenda approved. Minutes for March 13 and 25 were reviewed and approved with corrections. Corrections to minutes of March 13: staff will change description of person providing public testimony to "person with disability".

Chair Baumeister III. HIPAA Panel (Health Insurance Portability and Accountability Act) (See Exhibit Materials 4a,b)

Gwen Dayton, Executive Vice President and Chief Counsel, Oregon Association of Hospitals and Health Systems (member of OHFB Quality Institute Workgroup) (See Handout under Presentations)

- Reported on Quality Institute Workgroup activities and upcoming recommendations.
- Reviewed background of HIPAA.

    - Oregon has adopted a parallel state law.
    - HIPAA described as a *"privacy floor, not a privacy ceiling."* Gwen Dayton
    - State law is limited by what HIPAA allows. Oregon described as more protective in some ways than HIPAA.
    - Gwen Dayton: *"HIPAA is permissive and not prescriptive . . ."*
    - Definition of "identifiable" records can depend on the community.
    - Disclosure: Covered entities (including treating physicians, insurance plans, and others) can disclose protected health information without patient release for three things: treatment, payment, healthcare operations.
    - Patient rights reviewed.
- Special laws in Oregon for Drug and Alcohol (state and federal laws that are more restrictive than HIPAA) and Mental Health (Oregon Law ORS 179.505).
- In communications between diagnosing/treating physicians, how much formality is required regarding forms and official permission?
    - Nothing needs to be signed to release information between two treating physicians. There is a verification obligation that the information is being disclosed to the correct person.
- Privacy and security regulations regarding faxing information are addressed under HIPAA.
- Other allowable disclosures under HIPAA.
    - State law requires disclosure (e.g., alcohol levels to law enforcement, child abuse, etc.), but only for what is requested.
    - Facility directory information, location, and *general* condition of patient (e.g. "stable") may be disclosed if patient does not opt out.
- Patients are given a Notice of Privacy Practices as required by HIPAA. At this time, they have the right to opt out of some disclosures. Patient can request a restriction, but it can be denied.
- Relative to physician's offices, is it typical for physicians to require patient authorizations as they enter into a physician-patient relationship?
    - It is not required and authorizations have time limitations. Cannot do a blanket authorization.
- Must have authorization in the absence of a legal pathway.
- Other patient rights include:
    - Requesting an amendment to the record. If denied, patient has a right to appeal.
    - Accounting of disclosures may be requested by patient, but there are many exceptions.
- In context of current Oregon health system practices reform, does HIPAA present any barriers?
    - Response was no; however, disclosure of electronic records raises challenges as provider will need to account for where the record is sent (in case patient requests amendment or accounting of disclosure) but will have less control of electronic records. Also, Oregon laws provide challenge around redacting electronic records: since multiple people could access the record, who should make the redacting decisions?
- Are there cost containment issues in relation to providers being unaware of the specifics of the disclosure law?
    - Providers would still be concerned about liability and litigation.
- Mental Health and Addictions treatment barriers?

- Stricter federal and state law around these areas (outside of HIPAA law) including 42 CFR part 2 (federal law) and state MH law (ORS 179.505. Also SB 163. Hospitals will often choose to "opt out" on behalf of patients to not disclose information as freely for mental health issues.

- Privacy discussed, noting that 87% of privacy breaches are by people authorized to use the system.

Jody Pettit, MD, Health Information Technology Coordinator, OHPR and Project director, Oregon Health Information Security & Privacy Collaboration (HISPC) (see Handout under Presentations)

- Excerpt from SB 329 in reference to information technology is quoted.
  - Pioneering language
  - Envisions a state that does not exist today in which the personal health record for every person can be accessed whenever and wherever under the individual's control.
  - Oregon's Health Record Bank project received a $5.5 million grant from Medicaid
- Barriers to personal electronic health record listed:
  - HIPAA privacy rule
    - Patients do not understand the flow of the information.
    - Holders of health information are not currently required to keep information in electronic format, or to keep standardized information
    - No legal framework for health record personnel under a personal electronic health record bank
    - Discussion on physicians interviewing patients with a laptop and seeing that as a barrier to conversation and if this perception is generational.
    - There is evidence that people will not share information if they perceive that information may be shared – will take steps to avoid identification such as paying in cash.
    - People do not understand what is allowed under HIPAA. Refers to sample of Notice of Privacy Practices.
    - Related information on Oregon's participation in Health Information Security and Privacy Collaboration (HISPC) examining privacy practices around the state, noting a documentary film on the benefits of the health exchange and introducing some of the privacy issues.
    - Related the various areas that information flow is allowed without the consent of the individual. There are state laws that provide additional protection.
    - Patient rights and denial of patient requests of these rights is overviewed.
    - Doesn't a patient have a right to have a copy of their record?
      - They do, it does not have to be electronic, and they can be charged per page and it doesn't have to be standardized.
    - Appeal process for a denial of a patient right is related. Enforcement has been limited. There are enforcement standards that could be invoked.
    - Opening health exchange in a way that is brokered by the patient. "We can look forward to a day where we have a longitudinal comprehensive record . . ." that will follow the person throughout their life. Shift is to give the patient control of the information.

- Misuse of information by a physician and penalty involved is discussed.
- Health information technology, as it pertains to 329, has been delegated by the Governor to the Health Information Infrastructure Advisory Committee (HIIAC) that was recently been formed. It was related that their first meeting is April 25.
- This work will be a huge shift in legal framework – question whether Committee can consider making recommendations at this time about federal barriers.
- Until legal logistics of personal control can be figured out, Health Information Exchange will be at a standstill.

Chair Baumeister **IV. Committee Discussion: Medicaid**

Deferred until after agenda Item V. EMTALA Panel.

Chair Baumeister **V. EMTALA Panels (Emergency Medical Treatment and Active Labor Act) (See Exhibit Materials 5a,b,c,d)**

State Representative Ron Maurer (Grants Pass) addressed the Committee and provided input on the concept of an EMTALA Waiver, as well as medical malpractice reform. **(See written testimony.)**

- Would you want to link following best practice guidelines to the kind of protection that might occur under malpractice/torte reform?
  - Representative Maurer answered yes and that OHSU and public entities will be linked to medical malpractice reform.
  - Relates that significant public dollars are now being put at risk in malpractice issues when, in most cases, efforts are being made to do the right thing.
- Dr. Michael Huntington: *"Threat of costs from medical care related to a bad outcome is largely related to the way we provide healthcare in our state and nation. If we remove that part of it, there will be less incentive for people to sue."*
- Barney Speight asked "Do you have information relative to the frequency of medical malpractice suits for cases relating to the hospital emergency department?"
  - Responded he did not. He related that many hospital malpractice suits started when they were admitted into ER.
  - Committee staff will obtain that information.
- Representative Maurer asserts that Oregon is ahead of the rest of the country in laws, etc. and states that EMTALA is significant for other areas of the country but less an issue here.
- Question asked if an EMTALA waiver is needed or a change in federal law?
  - Stated the law could not be changed and it was about interpretation. How do you divert people who don't belong in the Emergency Room?
  - Taking primary care out of hospital ER is discussed.
  - [Staff note: EMTALA is not waiverable.]

Bob Lowe, MD, MPH, Director of the Center for Policy and Research in Emergency Medicine, OHSU (see PowerPoint presentation)

- Dr. Lowe is not representing OHSU in his comments today.
- Background of EMTALA related.

- EMTALA violations exist – hospital incentives haven't changed.
- Risks of modifying EMTALA – are there few enough cases of patient harm that we just have to accept that risk? Modification may decrease costs and increase efficiency – but this assumes that emergency department care is unnecessary, expensive, and a problem of personal responsibility/education?
- Related study results identifying cases of patient harm for those triaged away from emergency department.
- Quoted Priscilla Lewis of the Providence Health Care System as relating that ED costs are about 5% of uncompensated healthcare. The larger cost is inpatient from conditions not managed in a healthcare setting until condition reaches a point where hospitalization is needed.
- Related that if 25% of ED use by OHP members was eliminated it would only reduce total OHP spending by approximately 2%.
- Provided evidence that assertions that ED users are uneducated, do not pay, or are drug and alcohol abusers are incorrect.
- Extensive use of EDs seems to be related to community/location and suggests that high use communities could learn from the ones that have low ED use.
    - Asked if there was a correlation between communities that are doing well and characteristics of the population.
    - Dr. Lowe responded that the further one lives from the ED, the less likely one is to go. Also, *"the number of primary care visits available in the community compared to the projected need for primary care in community is a significant predictor of use."*
- Use of ED is related to access to care in the community.
- Related actual case scenario where loss of benefits resulted in loss of job, more health problems, visits to ER and being unable to pay.
- Asserts that EMTALA should remain and the real issue is to improve access to primary care.
- Urgent care facility within ED discussed.

Gary Young, MD Emergency Department, Sacred Heart Health Center (Eugene) (by phone) provides testimony in support of EMTALA.

- Provided information on results due to changes in OHP restricting coverage to participants.
- EMTALA affects the decision a specialist might make for being on-call, since some on call specialists are unpaid for being on call and EMTALA is unfunded.
- Discussed potential violations of EMTALA are mostly in relation to paperwork errors. Case of hospital being investigated for EMTALA violation where investigators reviewed documentation for many additional unrelated cases and found paperwork violations with $50,000 fines per case.
- Problems of accessing psychiatric care in rural Oregon and transferring patients throughout the state.

Michael McCaskill, MD Emergency Department, Rogue Valley Medical Center (Medford) (See PowerPoint presentation)

- Related lack of psychiatric care availability.
- Described current mental holds. Hospitals that meet criteria for mental holds and the problem for rural ERs. Hospitals have an obligation under EMTALA to stabilize, but some cannot impose mental health holds to do so.

- Slides 4-5 depict several examples of hospitals not being able to hold psychiatric patients and conflict between ER doctors and county mental health.
- Conflict between EMTALA and the Department of Human Services (DHS) requirements is discussed.
- How much is it a problem of state regulations in conflict with EMTALA and how much is due to a bad system?
    - Dr. McCaskill responded that doctors feel "out of the loop" and disagree with county mental health staff frequently. Mental Health Director's hold for transfer can be used, but if they don't agree doctor has no choice but to release the patient.
    - A conflict of interest exists as county mental health must pay for any transport out of their limited budget.
- Has the crises center in Grants Pass been helpful in alleviating the Three Rivers facility?
    - It has helped in Medford also. Not completely secure, but is a used resource. Three Rivers can hold patient for 12 hours.
- Is DHS aware of the conflict between EMTALA and state regs?
    - Not aware of any documented complaints to DHS.
- Does federal law (EMTALA) trump state law?
    - There has been no interpretation.
    - In case of a contrary opinion by a health professional (psychiatrist) there is at least an allegation under EMTALA there has been stabilization.
        - Doctor, particularly a psychiatrist, can remove a hold on a patient.
- Have you seen a difference between the time when the Oregon Health Plan included mental health care and now?
    - Described differences of involvement by county mental health departments and the continual decline in treating mental health patients. He stated that decline in care was not due to EMTALA.
- Solutions offered – see slide 10.
- How do you ensure that a facility has the appropriate accommodations to prevent abuse? Are the DHS rules onerous?
    - Dr. McCaskill responded that they can take care of a psychiatric patient for 12 hours but do not meet DHS rules and regulations of a "safe room".
    - Is this issue being discussed elsewhere?
    - Doctors and Attorneys are meeting to address the issue through the hospital association.
    - If you were allowed to hold someone for 12 hours would you be able to find a place for them after that time?
        - Responded that he was not sure, and possibly not.
    - Barney Speight stated that he would relate the problem of conflicting laws to DHS.
    - The state of mental health care in Oregon is discussed.

John Moorhead, MD Department of Emergency Medicine, OHSU (See written testimony)

- Provided testimony on additional crises in Emergency Care and stated that it is not an ER problem but *"a symptom of a health care system that's broken."*
- Balancing use of ED during its "stand-by" time and overwhelming it.
- Episodic care costs are comparable to physician office visits.
- Largest providers of uncompensated care are emergency physicians.

- These physicians see where policy solutions impact care. Changes in policy decisions results in changes at EDs.
- Only 12% of care given in the EDs could be treated in a less acute setting, representing a very small portion of health care spending.
- ED utilization in countries with 100% healthcare coverage is the same as in the U.S. Patients avoid health care rather than wait for hours in the ED.
- EMTALA legislation background related.
- Overcrowding, disaster care and workforce issue are discussed.
- Federal legislation introduced by the American College of Emergency Physicians is described which deals with some reimbursement for uncompensated care and liability relief for EMTALA providers.
- Discussion of ED overcrowding as a reflection that there is no room in ICUs – leads to "boarding" in the ED.
- Major success has been accomplished through advance directives and providing care from knowing what the family wants and not providing unwanted, unnecessary and expensive care. Board recommendations are forthcoming on this subject.

Chair Baumeister

Return to Agenda Item IV. Committee Discussion: Medicaid (See Exhibit Materials 2)

Staff overviewed the materials for discussion.

- Findings under first goal of reform related.
  - Concern stated regarding changes in waivers and effects on budget neutrality. Any expansion should include re-projection to ensure budget neutrality.
  - SCHIP reauthorization, caps, crowd-out and argument of potential of coverage shifting from private to public were discussed. Assumptions based on modeling vs. experience explored.
- Findings under second goal of reform related.
  - Payment Structure Flexibility: (Page 5) Discussion of language on #5 regarding payment for "outcomes." Outcomes used in reference to providing good management for a patient. Suggestion to replace "outcomes" with "documentation of best practices."
  - Primary Care Case Management (PCCM) discussed.
  - Problems of CPT codes used for payment, Kaiser payment system, and Medicare as risk adjusted is discussed.
  - Discussion on practitioners dictating patient notes for coding.
  - CMS rules (pages 5-6) with clarification that provider tax is coming into effect, others are proposed and there is a proposed one-year moratorium on rules.
  - Table of CMS rules (page 6) in relation to Oregon Medicaid Reduction/Cost column explained.
- Medicaid Issues Still to be Researched (pages 7-8) is reviewed
  - Impact of insuring all Oregonians.
  - Possible mental health barriers including the 16-bed limit.
  - Staff will forward a summary of meeting with DHS Addictions and Mental Health office.
- Correction on page 1
  - Under "Oregon Income Limits for Coverage" column, for FHIAP row, 85-185% should be 0-185% and asterisk note should read "…all FHIAP benefits for those 0-85%FPL *from the individual market* will be terminated…"

- Question on how much state money would be required to maximize federal match (page one, 2nd paragraph, 2nd sentence). Working on the number but roughly $250 million per year.
- Effect of waivers and budget neutrality readdressed. Can waive rules but cannot increase federal expenditures. Staff will add caveats regarding budget neutrality and the SCHIP cap, potential limiters of federal match.
- Julie James will work with staff in revising the organization of findings.
- Opportunity to dramatize findings at community meetings being held by the Board noted.
- Staff urged members to email comments on the Medicaid document.

Other discussion

- Does EMTALA need changing? Testimony by EMTALA panel discussed. Broad support for EMTALA expressed.
- What was heard today was contrary to what is being stated that ER is too expensive and what was heard today is totally different.
- Byzantine system that doesn't allow type of innovation that is needed. System was created over 40 years ago and is just being tinkered with but will not work. Need transformational change.

Chair Baumeister VI. Public Testimony

Scott Gallant, OMA provided testimony:

- Serious geographic payment disparities are a barrier.
- Oregonian article on chronic care management.
- CHAMP Act included additional payment in states like Oregon (will send staff copy of bill)

Written testimony on privacy laws submitted by Chris Apgar, Apgar & Associates.

Chair Baumeister VII. Adjourn

The meeting was adjourned by Chair Baumeister.

Next meeting April 22, 2008.

Submitted By:
Paula Hird

Reviewed By:
Susan Otter

EXHIBIT MATERIALS

1. Draft Agenda for April 8 meeting
2. Medicaid Draft Findings April 8
3. Federal Laws Meeting Minutes
   a. March 13, 2008
   b. March 25, 2008
4. HIPAA
   a. HIPAA summary from OAHHS website
   b. OAHHS Sample Notice of Privacy Practices
5. EMTALA:
   a. ACEP EMTALA fact sheet
   b. Emergency Room Use. Excerpts from: Trends in Oregon's Healthcare Market and the Oregon Health Plan, Report from 74th Legislative Assembly
   c. Letter to Federal Laws Committee on EMTALA from Robert Lowe, MD, MPH, OHSU Center for Policy and Research in Emergency Medicine
   d. "The Scapegoat: EMTALA and Emergency Department Overcrowding" Laura D. Hermer, *Journal of Law and Policy*, pp. 695-733 (Vol XIV, No. 2, 2006)
6. Summary of Oregon's OHP2 Medicaid Waiver
7. Public Comment: Apgar Privacy Law letter
8. OHFB April Newsletter

PRESENTATIONS

1. Gwen Dayton's handout on HIPAA
2. Dr. Jody Pettit's handout and testimony on HIPAA
3. State Representative Maurer's EMTALA testimony
4. Dr. Bob Lowe's EMTALA presentation
5. Dr. John Moorhead's EMTALA testimony
6. Dr. Mike McCaskill's presentation on Psych Holds

OREGON HEALTH FUND BOARD – Federal Laws Committee

March 25, 2008 **CCC – Wilsonville Training Center Rooms 111-112**
1:00 pm – 5:00 pm (Digitally Recorded) **Wilsonville, Oregon**

MEMBERS PRESENT: **Frank Baumeister, M.D., Chair**
Ellen Gradison, Vice Chair
Mike Bonetto
Chris Bouneff (by phone)
Michael Huntington, M.D.
Julie James (by phone)
Mallen Kear, R.N.
Sharon Morris
Larry Mullins
Nicola Pinson
Thomas Reardon, M.D.

MEMBERS EXCUSED: **Cheryle Kennedy**

STAFF PRESENT: **Susan Otter, Policy Analyst**
Barney Speight, Executive Director, OHFB
Erin Fair, University of Oregon Law Student, OHFB Intern
Judy Morrow, Assistant

ABSENT STAFF:

ISSUES HEARD:

- **Call to Order**
- **Approval of Agenda**
- **Presentation by Governor Kitzhaber**
- **Committee Discussion: Medicare**
- **ERISA Presentation and discussion**
- **Federal Tax Code Presentation and Discussion**
- **Public Testimony**

(Digitally Recorded)

Chair Baumeister **I. Call to Order**

- There is a quorum.

Chair Baumeister **II. Approval of Agenda (See Exhibit Materials 1)**

Agenda approved. Minutes for 03/13/08 to be reviewed at next meeting.

Presentation **III. Governor Kitzhaber (See Power Point presentation)**

Former Governor Kitzhaber addressed the scope of the Federal Laws Committee and presented on transformational change of the health care system. He commented that Committee's statutory charge is fairly narrow and misses the larger context.

- Complexity of system can be organized into a framework for change: (1) Wellness system; (2) Medical System; and (3) Financing and Economic Model.
- People are not healthier though cost has grown.

- Premiums have increased 8x faster than wages since 2000.
    - xx
    - 1. Unsustainable fiscally
    - 2. Not producing good outcomes.
- *"If healthcare spending was equal to population health we'd be the healthiest nation in the world but many nations have health statistics far below ours even though they spend much less."*
- Current system is the problem and changing the way you pay for it will not solve the problem.
- Look at three things:
    - Factors that keep people healthy
    - Where most of money is being spent
    - Demands on delivery system have changed but system has not evolved.
- We have a "sick-care" system – 90% of what affects health is not medical care.
- Financial incentives reward acute care interventions and discourage reorganization around chronic care management: cure, prevention, health improvement are not billable events.
- Structural problems and lack of data related.
- Need transformational change in both delivery and financial systems – cannot accomplish this through incremental changes to current system.
- The need for an agreed upon *"shared vision"* on what is the purpose of our health care system.
- Need to improve population health, reduce per capita costs and improve patient outcomes, safety and satisfaction. Economic/demographic implications of Medicare can't be overlooked.
- Cannot solve at the state level unless we can change the federal programs, but states can be instrumental in forcing change by challenging the federal government. Oregon did this with OHP waiver.

Discussion / Questions

- Any discussion within Board/Committees for including healthy practices in billing structure?
    - Barney Speight related that integrated health home is working toward that ends.
- Does expanding the Oregon Medicare Advantage model seem rational in the short-term?
    - As a short-term step that works, but need a strategic plan for long term that must lead to well-defined reform structure.
- End-of-life costs as a large proportion of health care costs is discussed.
- Creative ways are needed to engage the market to drive it toward some larger social objective – similar to energy industry cap on CO2 emissions. Discussion on changes in tax codes.
- Question on Medicare Advantage managed care as being effective while there is a lack of oversight of the Medicare Advantage model, and concern that CMS does not have the information on what was spent on extra benefits, administration costs or marketing.
    - Transparency is needed. Medicare Advantage as basic package of care that will ultimately be paid for by public funds with additional coverage bought by individuals if wanted.

- Categorical eligibility is counter to underlying premises of United States. Governor Kitzhaber presented the question: *"How much claim should one individual have on resources held in common to finance the cost of his or her own health care? At what point does the expenditure of an individual impinge on others to get care must be answered."*

Chair Baumeister **IV. Committee Discussion (See Exhibit Materials 2,3,4)**

- Barney Speight responded to the Medicare Advantage statement of hidden costs relating it is highly regulated and should be able to obtain data on how that money is spent.
- Committee discussed:
  - Tom Reardon brought up social and cultural values of the country as dictating the health care system and public perception of healthcare reform;
  - Costs will go up until the fundamental system is changed,
  - Costs on caring for the aging – patients will demand intervention, people will get older and get chronic disease - we still do heart bypass surgeries on 85 year olds.
  - Ethical limits conference will be attended by Michael Huntington and Barney Speight is discussed.
  - Barney Speight pointed out that the Committee has the freedom to write aspirational goals, but would also hope the Committee provides short term recommendations too;
  - The connection between the work before the committee and the Board's vision for reform (see Exhibit Material 3)
    - Can move forward from design assumptions
    - Health equities "weaves" through all of it
    - Stages of expansion
  - Delivery Committee's strategy recommendations to the OHFB – will demand change not just expand access to current system;
  - Barney Speight discussed timelines,
    - Mid-Late July direction from the Board on all committee recommendations.
    - Federal Laws Committee can submit a draft report around what's been heard, but may change emphasis after the Board's draft recommendations come out in July. General agreement to add a Committee meeting to reassess the draft report in July.
  - Barney Speight mentioned draft Medicare findings/recommendations (Exhibit Materials 4) for Committee comment.

Chair Baumeister **V. ERISA Presentation and Discussion (See Exhibit Materials 5a,b,c,d,e)**

Barney Speight introduced **Patricia A. Butler, JD, DrPH,** Attorney and Doctor of Public Health, who gave a presentation by phone on "ERISA Implications for State Health Care Access Initiatives"

Discussion/Questions

- What are the implications of an individual mandate?
  - Plan must meet a standard that is not necessarily filled by employer, then a legal challenge is possible but not likely (this is the case in Massachusetts).

    - If raised, what would prevail? Depends, to some extent, on what court the case was heard in. If law doesn't tell employers what to do, it would be pretty defensible.
    - States should not be daunted by ERISA, but it is hard to live with uncertainty
- How does the business community feels about the individual mandate being preempted by ERISA?
    - The speaker reported limited feedback but related not a major concern.
    - Involvement of employers in discussion and Massachusetts experience related.
- Does the Travelers case safeguard states against ERISA issues around imposing provider taxes?
    - Yes. Some cases have upheld this - Federal court of appeals case concerning Minnesota/Connecticut related.
- What are the ERISA implications for "pay-or-play" payroll taxes? (see slide 11)
    - Massachusetts model – pay or play doesn't dictate level of benefits offered to be eligible for waiver of payroll tax.
- Scenario of a pay-or-play tax and minimum creditable coverage discussed.
- If the state applies a tax and tax credit, does that avoid the ERISA question?
    - Employer could argue they are subject to double tax and connection to payroll tax. Suggested to have completely separate source of revenue through state income tax program that could avoid an ERISA problem.
    - Further discussion by the Committee and presenter, including tests for credits.
- What is the feasibility of Oregon's Department of Labor collecting data on the number of lives in state being covered by self-insured plans?
    - Seen as "connected to ERISA plans," ERISA already requires some reporting to federal government, talked about in other states but not tried, and possible litigation if employer refuses.
    - Could attempt to make reporting such data a condition of "pay or play" tax credit or deduction. Could impose reporting requirement on third party administrators (TPAs) of self-insured plans, particularly if TPAs already collected this info.
- What do you think could be done to change the ERISA law itself?
    - This has never been successful. Some states have raised challenges to ERISA through specific reform efforts. Opponents would be big business and big labor unions. Talking to congressional delegations, previous challenges and Hawaii exemption discussed.
- Any discussion for setting federal standards in ERISA that would be a ceiling beyond which a state couldn't go that would create a safe harbor around pay-or-play?
    - Joel Ario (Pennsylvania) in National Association of Insurance Commissioners (NAIC) may be working on this.

The Committee thanked Patricia Butler. Barney Speight shared that she is on a sub-contract through Institute for Health Policy and Solutions.

- Larry Mullins: consider pay or plan to include both tax deductions and credits.

- Sharon Morris: Concern that if standards cannot be set for benefit level of employer plans that employers will diminish coverage over time.

Chair Baumeister VI. Federal Tax Code Presentation and Discussion (See Exhibit Materials 6)

Chris Allanach, Oregon Legislative Revenue Office, presented.

- Mr. Allanach discussed the handout. Noted that dollar amounts listed as "revenue impact" are the amount of taxes that Oregon would have collected for 2007-2009 had the tax provision not been in place.
- Handout includes only income tax benefits. Tax benefits for the employers for health insurance contributions will be provided to the Committee if requested.
- Example given and discussion of state disconnecting from federal tax policy, e.g., regarding a change in 2008 Oregon tax of corporations of the Medicare Part D exclusion (see page 2).
- Discussion of when Health Savings Accounts (HSAs) can be utilized.
  - Credit allowed in absence of employer insurance
  - Once covered by employer health plan cannot be used in same way
  - Can contribute once covered but must be coupled with high deductible plan.
- Schedule A itemized deductions overviewed and discussed.
- Oregon's subtraction for "Additional Medical for Elderly" is discussed, including eligibility at age 62, a departure from the federal government and described as an age-based rate drop.
  - Related that discussion is ongoing to phase out for higher income.
- Tri-Care subtraction used to offset low payments to providers.
- Costs in Lieu of Nursing Home for low income and cap discussed.
- Discussion that additional deduction at age 62 is somewhat discriminatory from a policy point of view.
- Discussion of 125 plans, employer cafeteria and premium only plans.
- Deduction values by income brackets explained.
- Restrictions and tax disadvantages for self-employed of health insurance deduction is stated.
- Least tax benefits available for those purchasing insurance on open market.

Chair Baumeister VII. Public Testimony

- Written testimony submitted by Ruth McNeill **(See Exhibit Materials 8)**
- Written testimony regarding personal health records submitted by Chris Apgar **(See Exhibit Materials 9).**

Chair Baumeister VIII. Adjournment

- May meeting will be Tuesday, May 13, 1:00 pm to 5:00 pm.
- Meeting topics discussed.
- Committee members will provide written comments to staff on draft findings/recommendations in preparation for future discussion.
- Meeting adjourned by Chair Baumeister.

Next meeting April 8, 2008.

Submitted By:
Paula Hird

Reviewed By:
Susan Otter

EXHIBIT MATERIALS

1. Draft Agenda for March 25 meeting
2. Draft Federal Laws Committee workplan for 2008 meetings
3. Federal Laws Crosswalk to OHFB Design Assumptions
4. Draft initial Medicare findings for discussion
5. ERISA materials:
   a. PowerPoint presentation: "ERISA Implications for State Health Care Access Initiatives", Patricia Butler, JD, DrPH, for presentation to the Oregon Health Fund Board Federal Laws Committee, March 25, 2008
   b. Pay or Play Background
   c. Background on Mandates
   d. "ERISA Implications for State Health Care Access Initiatives: Impact of the Maryland 'Fair Share Act' Court Decision," Patricia Butler, JD, DrPH, State Coverage Initiatives Report, Nov. 2006
   e. "ERISA Update: Federal Court of Appeals Agrees ERISA Preempts Maryland's 'Fair Share Act'," Patricia A. Butler, JD, DrPH, State Coverage Initiatives report, Feb. 2007
6. Health Related Tax Expenditures and Estimated 2007-09 Revenue: Impact for Oregon, from Chris Allanach, Oregon Legislative Revenue Office
7. Medicare Research:
   a. "Health Care Costs Drive Up the National Retirement Risk Index," Alicia H. Munnell et. al., Center for Retirement Research, Number 8-3, Feb. 2008.(from Governor's Commission on Senior Services)
   b. Medicare Advantage bids, benchmark rates, rebates, compared to FFS by State
8. Ruth McNeill email March 2, 2008
9. Chris Apgar letter regarding personal health records, March 5, 2008

PRESENTATION

1. Gov. John Kitzhaber's presentation

OREGON HEALTH FUND BOARD – Federal Laws Committee

March 13, 2008 **Oregon State Library, Room 102-103**
9:00 – 12:30 pm (Digitally Recorded) **250 Winter St. NE, Salem, OR**

MEMBERS PRESENT: **Frank Baumeister, M.D., Chair**
Ellen Gradison, Vice Chair
Mike Bonetto
Chris Bouneff (by phone)
Michael Huntington, M.D.
Julie James (by phone)
Mallen Kear, R.N.
Sharon Morris
Larry Mullins (by phone)
Nicola Pinson
Thomas Reardon, M.D.

MEMBERS EXCUSED: **Cheryle Kennedy**

STAFF PRESENT: **Susan Otter, Policy Analyst**
Barney Speight, Executive Director, OHFB
Erin Fair, University of Oregon Law Student, OHFB Intern
Judy Morrow, Assistant

ABSENT STAFF:

ISSUES HEARD:

- **Call to Order**
- **Approval of Agenda and February 28 Meeting Minutes**
- **Medicare Panel: Medicare Advantage HMO and PPO Plans**
- **Medicare Panel: Medicare Advantage Special Needs Plan**
- **Presentation by Oregon Insurance Administrator**
- **Committee Discussion**
- **Public Testimony**

(Digitally Recorded)

Chair Baumeister I. Call to Order

- There is a quorum.

Chair Baumeister II. Approval of Agenda and February 28 Meeting Minutes

Motion to approve the minutes as written is seconded. **Motion passed unanimously.**

Chair Baumeister III. Medicare Panel: Medicare Advantage HMO and PPO Plans

Presentation by Kevin Keck, MD, Chief Medical Officer, Providence Health Plans (HMO). (See presentation)

- Presented on the strengths of the Medicare Advantage Model as a strategy to mitigate the problems of the traditional fee-for-service Medicare.
- Universal Health Care will not solve the problem of rising costs.
- Value based payment is step in correct direction but it is not enough.
- Imaging is the highest rising cost of the health care dollar.

- Minimal interaction with MDs leads to patients not understanding and not following instructions.
- Providence uses a "systems of care" approach. Manage chronic, high cost conditions to prevent high costs. Actively promoting generic drugs
- Discussion of Medicare Part D: treatment panels are working and can be enhanced. CMS requires medication treatment management which helps us identify members who could benefit from care management.
- Creating access by paying 1.17 times the traditional Medicare rate to physicians. On commercial side, using a "pay-for-performance" including increased pay if providers accept Medicare Advantage members.
- Provider network is stable – very few providers dropped Medicare Advantage participation, many more quit traditional Medicare.

Discussion

- Question on customer satisfaction and prior authorizations on radiology.
    - Use American College of Radiology guidelines. High satisfaction even given prior authorizations for some drugs, radiology and spinal surgery.
- Question on cost quality strategy – investing in aggressive primary care management.
    - Four opportunities: (1) Reduce unnecessary healthcare; (2) American healthcare getting it right; (3) prevent avoidable admissions (4) manage sickest proportion of patients.
- What led to development of Providence systems of care approach?
    - Providence is mid-sized and could move quickly, Medicare Advantage pushed us to control costs because we're taking on the risk, carved out mental health.
- Dr. Keck responded to a question on what are the current limitations within Medicare Advantage and how could these be fixed?
    - CMS could add requirements for managing care of sickest members or for tracking radiology trends.
    - Difficult to identify the 1% of members who cause 30% of costs – we have some tricks and software to find them.
    - We pay providers to send us performance information and then feed it back to them. Have found performance goes up.
- Question about barriers to cooperation between insurance companies and avoiding adverse selection under Health Insurance Exchange.
    - Think cooperation is possible.
- Administration costs are about 10%. 2,000 physicians are contracted with Providence, of those 140 are employed by Providence. Providence contracts with most of its physicians and is not a Kaiser-like program.
- Question on whether members are dis-enrolling.
    - Very few dis-enroll. Seniors tend to stick with a plan.

Daelene Schwartz, Medicare Product Line Director, Kaiser Foundation Health Plan of the Northwest (HMO)

- Provided background on Medicare Advantage funding and history.
- 1997 BBA included capping high rate counties and creating floor counties with guaranteed rate increases to gradually move to more equitable national payment.

- Medicare Modernization Act (MMA) enacted 2003, implemented in 2006.
  - Changed payment methodology to a more complex system.
  - Related how payment is calculated: Medicare Advantage plan calculates a 'benchmark' of what it thinks CMS will pay using county floor and risk adjustment based on disease burden and geographic elements. Plans calculate 'bid' – projected costs to care for the population (almost always below the benchmark). MA Plans get rebate of 75% of difference between bid and benchmark (if bid is below benchmark) which must go to enhancing benefits.
- Oregon MA plans pay approximately 133% of traditional Medicare fee-for-service rates (average between HMOs and PPOs). Policy debate around whether Medicare should only pay for core benefits.
- Committee debated that extra 33% does not reflect a true difference in payment, since it includes additional items.
- Issues and barriers of MA plans discussed.
  - Model has positive points – quality of care
  - Payment system needs revising to be equitable and address costs of care, allow for coordination of care, and be stable and consistent
  - Regulatory complexity – example of Part D which is very complicated and includes lots of reporting, hundreds of issuances from CMS, and is very complicated for beneficiaries.
  - Recommendation of simplicity of plan design.

Pat Gibford, CEO, Clear Choice Health Plans (HMO), (See presentation).

- Clear Choice is a small group, "*Niche player"* 12,000 lives covered. Serve rural counties. First provider sponsored organization to get Medicare Advantage contract.
- Western Montana physicians see MA as preferable to traditional fee-for-service Medicare because of systems of care approach and higher reimbursement.
- Policy discussion about limiting Medicare Advantage payment to traditional Medicare levels would be a problem considering that traditional Medicare rates vary by service areas. We'd love to get Miami, FL traditional Medicare rates.
- Current issues for MA plans:
  - Lack of understanding of contribution/value of plans (e.g., systems of care).
  - Reimbursement for floor counties
  - Access to primary care providers is limited for Medicare beneficiaries even with a Medicare supplement plan. Can often get access under Medicare Advantage.
  - Provider reimbursement and self-referral for ancillary services. Nine MRI scanners in Bend are difficult to manage.
  - Increasing costs and utilization and higher MLRs.
- Federal Policy issues:
  - Oregon MA plans lack clout in Washington DC, MedPac doesn't reflect localities and doesn't acknowledge the access problem.
  - Private Fee-For-Service Medicare Advantage plans (PFFS) and Prescription Drug Plans (PDPs) lack CMS controls. Confusion of initial implementation of Part D – many retroactively disenrolled.
  - CMS often makes changes without first testing.

    - System is unsustainable.
    - Ethics of limits on treatments.
- Question on whether multiple insurance plans could coordinate under Health Insurance Exchange. Pat Gibford responded that the cost would make this prohibitive.

Bart McMullan, MD, President of Regence Blue Cross Blue Shield of Oregon (PPO)

- Have moved HMO models to PPO.
    - Regulated essentially the same way as HMO but PPO offers greater flexibility for members who can get some coverage out of network.
    - Parts of country HMO model does not work because there aren't many providers available.
- Regence pays more than Medicare.
- Access to providers is easier for PPO members than under traditional Medicare. Regence has no physicians in its network refusing new MA members.
- Question on whether multiple insurance plans could coordinate under Health Insurance Exchange. Responded that coordination could happen on quality measures but would still compete for the dollars.

Discussion

- Risk adjustment is a better model for MA plans – we're not penalized for doing a good job managing care
- Question on sustainability considering cost containment – Consumer Price Index + 1 is the Holy Grail of sustainability. We can't get there without cost containment strategies and a change in culture around ethical limits to treatment. Realign incentives for paying providers to keep patients out of hospitals – could take money saved on inpatient care and pay doctors for prevention and outcomes. 60% of Medicare payments are spent in the last 6 months of life.
- Question on hospital incentives for participating in Medicare Advantage – MA plans pay hospitals more than traditional Medicare. However, if systems of care work and can manage outpatient side then hospitals may end up with fewer inpatients. May need to redistribute some of the savings to hospitals. May be some advantage to hospitals: hospitals' margin is more on the surgical side than the medical side and Medicare Advantage members will tend to be hospitalized more for surgeries than for other medical reasons.
- Question about need to increase primary care work force – all agreed this was a huge issue and wouldn't happen under the current model, especially difficult in rural areas.
- Question on whether insurance companies can cooperate with each other in light of anti-trust laws. Oregon Quality Corporation is working on this – including Medicare, Medicaid, and commercial data.
- Discussion on rural area care and availability of Medicare Advantage plans in rural Oregon.
- Staff will put together data with penetration level for rural areas with distribution of HMO's and PPO's.

Chair Baumeister **IV. Medicare Panel: Medicare Special Needs Plans**

Patrick Curran, Medicare Director, CareOregon (See presentation)

- CareOregon SNP serves 5,300 dual eligibles (who have both Medicare and Medicaid) in 9 Oregon counties. Members access nearly all care

through CareOregon – carve out for dental and mental health care. Most states don't put dual eligibles in managed care.
- Benefits of integrated care discussed. Can easily sign up OHP enrollee in Medicare too, care coordination and community resources – can link to housing services, etc. Access: providers are open to new members.
- FFS reimbursement limits discussed.
- Discussed exceptional needs coordinators for OHP and Medicare members.

Kelly Kaiser, CEO, Samaritan Health Plans (See presentation)
- CMS is no longer accepting applications for new SNP plans and will not accept expansion of existing SNP plans starting Jan, 2009. Think this is due to unexpected influx of SNP plans.
- Samaritan offers a managed care SNP for dual eligibles, started in 2005. Discussion of start up process.
- Benefits of their SNP: Access to providers is contractually guaranteed, higher reimbursement rates for providers, community based plan, provider billing is simplified, mental health benefits are coordinated, one case manager or ENCC manages each member's care

Discussion
- Discussion on CMS restrictions on SNP plan expansions/applications: perhaps lots of SNP applications because costs can be managed and high cost population can be carved out which lowers Medicare Advantage bid.
- Now CMS requires SNPs send data separately from other Medicare Advantage plan data.
- Risk adjustment is based on diagnosis – heard about one chronic care SNP for high cholesterol – think CMS was overwhelmed.
- SNPs for duals offer true benefits to members and should expand.

Chair Baumeister V. Presentation by Scott Kipper, Oregon Insurance Administrator
- Regulation of Medicare supplement products: National Association of Insurance Commissioners (NAIC) has authority to develop products. Products are approved at state level. Discussed loss ratios for individual and small group products.
- Medicare Advantage plans have very little oversight – state oversees solvency of carriers, licensure of insurance agents. No state oversight of product design, marketing practices by plans, etc. – these aspects are overseen by CMS.
    - Have seen documented marketing abuses mostly by agents, not carriers. In Louisiana, Scott Kipper saw abuses such as knocking on doors and refusing to leave until senior signs up, setting up tables at assisted living and senior centers to get seniors to sign up. Abuses mostly on PFFS side (not HMO/PPO)
    - Some interest in Washington DC in providing states with more oversight role. Think proposal will be to give states similar oversight to Medicare supplement oversight, which he would strongly support. State oversight allows states to get rid of marketing abuses and provide consumers with a local outlet for their concerns.

- Discussion of focused role of an Exchange and how rules would be enforced.

Chair Baumeister VI. Medicare: Committee Discussion

- Barney Speight inquired if the Committee had specific requests for information.
  - Unaccountability of payments and rebates of Medicare Advantage Plan. Staff will follow up on all plans and what kind of transparency exists now.
  - Research on what is possible within Medicare/Social Security Law for Health Fund Board recommendations.
  - Clarification/accuracy of the 133% payment difference to physicians
  - Question about Medicare Advantage open enrollment and being able to change plans, and formulary changes for Part D plans.
  - Concern that CMS doesn't have data to justify higher rates for Medicare Advantage plans.
- Recommendations on approach by committee.
- Need for relief on Medicare fronts.
- Implications of ERISA, e.g. individual mandate
- Oregon Quality Corporation, a 501(c) 3 program, discussed.

Chair Baumeister VII. Public Testimony

- **Debby Schwartz, Archimedes Member, person with disabilities on Medicare,** addressed a previous comment concerning people tending not to switch out of the Medicare Advantage plans: mentioned enrollees are locked in for one year. Provided testimony on personal experiences with Medicare.

Chair Baumeister VIII. Adjournment

Meeting adjourned by Chair Baumeister.

Next meeting March 25, 2008.

Submitted By:
Paula Hird

Reviewed By:
Susan Otter

EXHIBIT MATERIALS

1. Draft Agenda for March 13 meeting
2. Feb 28th draft minutes
3. Medicare themes presented to Committee
4. Medicare Advantage background:
   a. Medicare Advantage background, including Special Needs Plans: MedPac Report to Congress, March 2008 (excerpt)
   b. Medicare Advantage and SNP enrollment, payment data
   c. "Medicare Advantage: Higher Spending Relative to Medicare Fee-for-Service May Not Ensure Lower Out-of-Pocket Costs for Beneficiaries" GAO report 08-522T, Feb. 28, 2008.
   d. "CMS to Investigate Use of Rebate Funds by Medicare Advantage Plans, Weems Says," National Health Law Program, Volume 13 Number 40, February 29, 2008
5. Medicare background
   a. Current CMS demonstration and pilot programs
   b. "Medicare: Starting Now on the Path to Higher Value," By Karen Davis and Stu Guterman, Commonwealth Fund, Feb. 28, 2008.
   c. OMA Letter to Sen. Wyden, Oct. 24, 2007
6. Medicaid follow-up:
   a. Report for US House Committee on Oversight and Government Reform, on the impacts on Oregon of CMS proposed rules, DHS Office of Federal Financial Policy, Feb. 15, 2008.
   b. "The Proxy War — SCHIP and the Government's Role in Health Care Reform," Sara Rosenbaum, J.D., New England Journal of Medicine, Vol. 359 No. 9, pp. 869-872, Feb 28, 2008.
   c. "New Medicaid Rules Would Limit Care For Children in Foster Care and People with

Disabilities in Ways Congress Did Not Intend," Judith Solomon, Center for Budget and Policy Priorities, Feb. 8, 2008.

   d. "Four States Ask Court to Overturn HHS Limits On Medicaid Payments for Case Management" National Health Law Program, Volume 13 Number 42, Friday, March 4, 2008

7. Other articles:
   a. "The Cost-Coverage Trade-off: 'It's Health Care Costs, Stupid,'" Ezekiel J. Emanuel, MD, PhD, JAMA 2008; 299: 947-949, Feb 27, 2008.
   b. "Who Really Pays for Health Care?: The Myth of 'Shared Responsibility'" Ezekiel J. Emanuel and Victor R. Fuchs, *JAMA.* 2008; 299(9):1057-1059, March 5, 2008.
8. Other Committee business:
   a. February OHFB report to legislature, includes revised design principles and assumptions
   b. March OHFB newsletter
   c. Affordability recommendations from the Eligibility and Enrollment Committee presented to the Oregon Health Fund Board on 2/19
   d. Eligibility recommendations from the Health Equities Committee presented to the Oregon Health Fund Board on 2/19
9. Public comment:
   a. Prof. Art LaFrance phone conversation notes

PRESENTATIONS/HANDOUTS:

1. Dr. Kevin Keck's presentation, Providence Health Plans
2. Pat Gibford's presentation, Clear Choice Health Plans
3. Patrick Curran's presentation, CareOregon
4. Kelley Kaiser's presentation, Samaritan Health Plans
5. Medicare Advantage enrollment in Oregon by region and plan type (HMO/PPO/PFFS)

OREGON HEALTH FUND BOARD – Federal Laws Committee

February 28, 2008 **NW Health Foundation, Bamboo Room**
10:00am (Digitally Recorded) **221 NW 2nd Ave, Suite 300, Portland, OR**

MEMBERS PRESENT: **Frank Baumeister, M.D., Chair**
Ellen Gradison, Vice Chair
Mike Bonetto
Chris Bouneff (by phone)
Michael Huntington, M.D.
Julie James
Mallen Kear, R.N.
Larry Mullins
Thomas Reardon, M.D.

MEMBERS EXCUSED: **Nicola Pinson**
Sharon Morris
Cheryle Kennedy

STAFF PRESENT: **Susan Otter, Policy Analyst**
Barney Speight, Executive Director, OHFB
Erin Fair, University of Oregon Law Student, OHFB Intern
Judy Morrow, Assistant

ABSENT STAFF:

ISSUES HEARD:

- **Call to Order**
- **Approval of Agenda and Minutes from Jan 23 and Feb 14 Meetings**
- **Committee Discussion: Medicaid**
- **Medicare Beneficiary Advocates Panel: AARP**
- **Medicare Beneficiary Advocates Panel: Governor's Commission on Senior Services**
- **Medicare Beneficiary Advocates Panel**
- **Committee Discussion: Medicare**
- **Public Testimony**

(Digitally Recorded)

Chair Baumeister I. Call to Order

- There is a quorum.

Chair Baumeister II. Approval of Agenda and January 23 and February 14 Meeting Minutes

Motion to approve the minutes as written is seconded. **Motion passed unanimously.**

Chair Baumeister III. Committee Discussion: Medicaid

Discussion concerning Committee's charge to evaluate how federal laws will impact healthcare reform in Oregon:

- Barney Speight, OHFB Director, related Board's timeline of draft recommendations by Late May to Mid or Late June, with public meetings to be held in September.
- Barney presented tentative framework of Board's reform that the Federal Laws Committee can work with:
    - Access expansion around Medicaid (some populations) and Family Health Insurance Assistance Program (FHIAP)
        - About 60% of uninsured are under 200% Federal Poverty Level (FPL)
        - 150,000 people are 300-400% of FPL
        - 40,000 people are 400% over FPL
    - Much can be done within Oregon's current waiver by adding State funds to expand coverage to the uninsured – OHP current waiver for up to 185% FPL, not being maximized, FHIAP limited by state funds
    - Individual mandate would lead to changes in voluntary market such as guaranteed issue. Would necessitate affordable insurance options.
    - Financing the reform package
    - Benefits package within reform
    - Waiver requests for federal match
- Discussion of how to prioritize federal Medicaid barriers heard so far. Much of what had been presented to the committee might not be top priority within the context of the Board's reform efforts. Committee should be strategic in report/recommendations – recognizing why federal policies exist, how we would change these and why these changes would be acceptable.
- Discussion of process of making recommendations to federal government:
    - Board's process – Oregon legislators would start by passing law to reform health care in Oregon. The legislation would need funding. This becomes the basis for requesting waivers or other federal changes.
    - CMS waiver process – DHS submits the waiver requests, CMS sets terms of accountability.
    - The report of the Federal Laws Committee will go to the Oregon Congressional delegation
    - Oregon Congressional delegation may want to put forth changes in law in Congress
    - Persuading CMS to make regulatory changes – would need a coalition of stakeholders
- Discussion of administrative rulemaking process and budget neutrality.
- One area of recommendations: ERISA law and the individual mandate
    - Federal regulation requires minimal reporting, states do not know the number of lives covered by self-insured plans
    - Law is vague resulting in problems with mandates and identifying acceptable funding strategies
    - What we know is due to the result of court cases
    - ERISA employers – approximately 700,000 employees in Oregon
- Committee discussed dividing recommendations into "buckets" and prioritizing each:
    - Waivers (Medicaid)
    - Statutory

    - Regulatory
- Discussion of including citizenship documentation requirements as a federal barrier to expanding access to Medicaid, staff research will look for alternative approaches to propose
- How much of problem is federal, how much is state? State financing is a major barrier in and of itself – there is nothing the feds can do about that. Significant eligible but unenrolled population - partly an outreach issue, partly a state financing strategy issue
- We should be careful not to confine our recommendations to fit within the current system because the current system is unsustainable - we need to think "out of the box" and make new and creative recommendations – new funding, new outcome measures, etc.
- New and innovative accountability standards, i.e. – coding/encounter requirements for reimbursement versus reimbursing based on overall clinical outcomes. Also need to think about how to keep responsibility/accountability standards of some kind, but avoid perverse incentives.
- Difficulty in persuading federal government that Oregon is different – same in provider community – Oregon is more efficient.
- Think about how to initiate "conversation" with CMS - through Senate/other Members of Congressional delegation, through CMS leadership, DHS can talk to CMS as waivers/changes are being developed.
- Staff will bring information to the Committee on the following:
    - Expanding coverage to uninsured by state action, not prevented by federal barrier
    - Citizenship documentation requirements preventing eligible low-income Oregonians from accessing Medicaid
    - Flexibility with provider payment structure (paying for outcomes not based on encounter or claims data) within Medicaid waiver
    - Barriers related to federal mental health funds not under Medicaid and 16-bed limit for Medicaid payment of residential mental health care
    - Strategies to avoid losing special funding for Federally-Qualified Health Centers (FQHC) and Rural Health Clinics

Chair Baumeister **IV. Medicare Beneficiary Advocates Panel: AARP**

Rick Bennett, AARP Oregon Director of Government Relations provided testimony relating:

- 500,000 members:
    - 50-64 – one half of the members
    - 65 + - one half of the members
- Divided We Fail movement goals:
    - Health & Financial Security
    - Engage Citizens
    - Communication with elected officials
    - Finding solutions
- AARP Oregon supported SB 329

Dr. Chadron Cheriel, AARP Oregon Executive Council member (See written testimony, Presentation Materials 1)

- Access, Quality & Cost Control are key to health care reform

    - Cost control, prevention and care coordination important for reform financing options
    - Care coordination, prevention and eliminating inefficiencies in financing and delivery would be beneficial
    - Overall rising health care costs is the real challenge. Medicare has benefited seniors financially, has low administrative costs, and has developed innovative cost-control strategies.
- Very little room to add health care costs to retired population
- Medicare offers portability, especially for seniors who reside in two different states over the course of the year. State-based programs would restrain portability.
- Part D prescription drug program – should raise asset limits for low-income subsidy, and should allow bulk negotiating/purchasing.

Kirsten Sloan, AARP (National-level) Legislative Health Team Leader

- Medicare should be reformed at the national level.
- Payment system rewards volume not quality
- Connection between FFS and managed care; states are penalized for efficiency
- Medicare Advantage (MA) discussed in US Congress - need greater balance between managed care and FFS: in 2006, $7.1 billion more spent in MA programs than would have been spent under regular FFS
- Reimbursement rates
    - How can we tie Medicare rates with quality of care?
    - Recognizing regional differences with rates including unique situations like Oregon, where FFS costs are lower.
    - CHAMP Act – on House (MA)
- AARP supports:
    - Evidence-based research
    - Health Information Technology
    - Chronic Care Management
    - Pay for Performance and value based purchasing
- 80% of beneficiaries are in traditional Medicare (nationally) and about 80% of these have supplemental coverage
- Discussion concerning Oregon having highest penetration of MA (approx 38%). There are three types: HMOs, PPOs & PFFS. Most in Oregon MA are in managed care. What is AARP's position for states that have a high penetration for MA, what to do about expanding service?
    - MA enrollment nationally increased from 16 to 20% penetration; PFFS comprise greatest growth but also have the most problems – don't have coordinated care, no prescriptions, no requirement to stay within Traditional Medicare reimbursement rates; also offer low or no premiums – so they are attractive to beneficiaries.
    - Problems with marketing tactics; people think they are signing up for a supplement program, but are actually replacing Traditional Medicare. People think they can access any doctor or hospital, but they can't.
    - MA "brand" is being degraded by these bad players; how do we expand MA HMO coordinated care – higher reimbursements & benefits of coordinated care? Should offer genuine package that meets coordination needs & an affordable premium

- Medicare Modernization Act – income-related requirements for cost sharing of up to 50% Part B premiums. Still cost-shifting, doesn't address underlying systemic issues. Also, policy issue - asking a sub population to pay higher amount for health care – at some point they are going to get out of Medicare because these are the people who can afford to get out; they also tend to be healthier and they have paid more into the system over the course of their career.
    - Don't have data on those opting out of Part B due to cost.
- New report being published this month from Medicare Trustees regarding insolvency of Medicare program. Senior community has high rate of growth – 90% in OR from 2000-2025, and 140% in Bend area alone. Some areas of the country can't afford to wait for larger Medicare reform – that's why chronic care management and health information technology can be so important now.

Chair Baumeister **V. Medicare Beneficiary Advocates Panel: Governor's Commission on Senior Services (See PowerPoint presentation, Presentation Materials 2)**

Chuck Frazier, Commissioner, GCSS

- Per a Oregon Physician Workforce Survey (see Exhibit Material 9), nearly one-fourth of physicians have closed services to new Medicare beneficiaries – reimbursement cited as most important reason.
- GCSS is co-sponsoring a Medicare Access project – hope to develop a registry and demonstrate lack of access.
- Implications of lack of access: patients delay care, increase system costs. Lack of patient advocacy – less likelihood of individuals following good health practices. GCSS recommends:
    - Increasing reimbursement rate for primary care providers
    - Recognize the cost of doing business or consider a balance billing waiver
    - Consider "concierge care" programs by primary care providers (PCPs)
    - Encourage all Medicare/Medicaid patients to have a PCP
    - Clarify to PCPs that their role includes patient advocacy and education
- Ideas of patient-directed care and patients shopping for health care may not be realistic since patients don't know the costs of care, billing systems are slow and difficult to decipher, and patients' ability to catch errors is limited. Recommend:
    - Mandate clear and timely medical billing system
    - Require specific information on bills (service dates, charges)
    - Find ways to stop drawn-out adjudication process
- Poor use of Information Technology (IT) – recommend incentives to accelerate the application of IT to entire health care industry
- Need for Liability Reform – practice of 'defensive medicine' increases costs of health care. Recommend revisions of tort laws.
- Avoid duplication and waste – example, distribution of medical equipment and facilities across state is often not adequate to meet need. Recommend – creditable 'Certificate of Need' program to match need with resource availability

Robert Lawrence, Commissioner, GCSS

- "50+ initiative" to identify concerns in Lake Oswego. Lack of access to medical care for Medicare beneficiaries was a major concern. Robert

couldn't find a physician in Lake Oswego to take Medicare, ended up on Kaiser Medicare Advantage plan.

Peggie Beck, Commissioner, GCSS

- GCSS supports the reform efforts of the Board

Chair Baumeister VI. Medicare Beneficiary Advocates Panel

Steve Weiss, President, Oregon State Council for Retired Citizens (See Exhibit Materials 10 and 11)

- CMS provides continuity. Should be commended for:
  - Changes in benefits and drug formulary
  - Medicare Part D adding drug benefits
- Objections to Medicare Advantage plans – payments to MA plans doubled since 2003, enticing more plans, quality is worse, health outcomes are worse (from national MedPac article). These plans are not less expensive, some are not managing care – money could be better used elsewhere.
- Oppose integration of acute and long-term care into Board's reform plan. If long-term care is included in managed care then seniors end up in nursing homes that could otherwise have stayed at home.
- Recommends allowing a Medicare Advantage plan that is a publicly owned non-profit.

Janet Bowman, SHIBA & Medicare Outreach Coordinator, Multnomah County Aging & Disability Services (See handouts, Presentation Materials 3)

- Beneficiaries have a difficult time understanding the differences between Medicare Advantage and traditional Medicare. Difficult to choose between 93 Part D prescription drug plans in Multnomah County. Need to provide clear benefit information to seniors – this will be important for the Board's reform package as well. SHIBA helps folks select plans.
- Part D formula and copay changes – beneficiary may stop taking a drug if copay goes up or it is dropped from formulary. Counseling is needed.
- Misunderstanding about what skilled nursing care Medicare pays for – 100 days but only if patient is making progress, otherwise Medicare stops paying.
- Long term care in Oregon is a model for nation – don't put medical model on top of long term care system. Long term care is about how people live in the setting they choose.
- Discussion about how beneficiaries make choices between plans and access to SHIBA volunteers across Oregon. SHIBA does not track which doctors have openings for Medicare patients. Find idea of 'physician extenders' such as nurse practitioners interesting.

Chair Baumeister VII. Committee Discussion: Medicare

- Discussion of Medicare payment rate setting – history of Geographic Practice Cost Indices (GPCI) and Resource-Based Relative Value Scale (RBRVS), sustainable growth rate. Suppressing fees for physicians in Medicare has led to a crisis in access.
- Access is the greatest issue in Medicare

- Changes to Medicare not possible through state waivers – really law or regulatory changes. May be some demonstration/pilot programs available – staff will research this.

Chair Baumeister **VIII. Public Testimony**

Written testimony submitted by:

- **Betty Johnson (see Exhibit Materials 12 and 13)** email comments and submission of Newsday article: Who's looking out for Medicare's health?

Chair Baumeister **IX. Adjournment**

Meeting adjourned by Chair Baumeister.

Next meeting March 13, 2008.

Submitted By:
Paula Hird

Reviewed By:
Susan Otter

EXHIBIT MATERIALS

1. Agenda
2. Meeting Minutes from 01/23/08
3. Meeting Minutes from 02/14/08
4. Medicaid Themes heard by Committee
5. Sum of Presentations of 02/14/08
6. KFF Medicare Primer
7. OHPR report: Oregon Medicare Background
8. Commonwealth: Bending the Curve
9. Oregon Physician Workforce Survey
10. Myths of High Medical Costs (handout from Weiss)
11. Medicare Advantage Special Needs Plans (handout from Weiss)
12. Testimony: Betty Johnson email
13. Testimony: Betty Johnson submission of Newsday Medicare article
14. Rhonda Busek, LIPA testimony at Feb 14 meeting
15. Deborah Loy, Capital Dental Care testimony at Feb 14 meeting
16. Angela Kimball, NAMI presentation at Feb 14 meeting
17. Scott Ekblad, Office of Rural Health testimony at Feb 14 meeting
18. Pam Mariea-Nason, CareOregon testimony at Feb 14 meeting
19. DHS Citizenship Report
20. NEJM Article: Does Preventive Care Save Money?
21. NY Times Article: Governor's of Both Parities Oppose Medicaid Rules
22. CBPP article: Medicaid Weakening
23. "State of the States report," States Coverage Initiative, Jan 2008 (The report is available at: www.statecoverage.net/pdf/StateofStates2008.pdf.)

PRESENTATION MATERIALS

1. Dr. Chadron Cheriel's testimony, AARP
2. Governor's Commission on Senior Services presentation
3. Janet Bowman's handouts, Multnomah County Aging & Disability Services Division

OREGON HEALTH FUND BOARD – Federal Laws Committee

February 14, 2008 **Oregon Medical Association, Sommer / McLoughlin Room**
9:00am (Digitally Recorded) **11740 SW 68th Parkway, Suite 100, Portland, OR**

MEMBERS PRESENT: **Frank Baumeister, M.D., Chair**
Ellen Gradison, Vice Chair (by phone)
Mike Bonetto
Chris Bouneff
Michael Huntington, M.D.
Julie James
Mallen Kear, R.N.
Cheryle Kennedy
Larry Mullins
Nicola Pinson
Thomas Reardon, M.D.

MEMBERS EXCUSED: **Sharon Morris**

STAFF PRESENT: **Susan Otter, Policy Analyst**
Barney Speight, Executive Director, OHFB
Jeanene Smith, Administrator, OHPR
Erin Fair, University of Oregon Law Student, OHFB Intern
Judy Morrow, Assistant

ABSENT STAFF:

ISSUES HEARD:

- **Call to Order**
- **Approval of Agenda**
- **Medicaid Panel: OHP-Contractors**
- **Follow-Up Mental Health Panel**
- **Medicaid Panel: Providers**
- **Medicaid Panel: Safety Net Providers**
- **Public Testimony**

(Digitally Recorded)

Chair Baumeister I. Call to Order

- There is a quorum.

Chair Baumeister II. Approval of Agenda

No questions on agenda. Minutes from Jan 23 meeting are not available – will be sent to members for approval at Feb 28 meeting.

Chair Baumeister III. Medicaid Panel: OHP-Contractors

Fully Capitated Health Plan: Pam Mariea-Nason, Legislative Liaison, CareOregon

- CMS is eroding opportunities for innovation – limiting funds and eligibility. CMS is enacting rules that are shortsighted and confused, and have a large impact, like the Deficit Reduction Act (DRA) of 2005.
- The current OHP system is too expensive considering the outcomes.

- CMS system of payments to providers is basis for even commercial payments to providers. System pays more for technical services and less for prevention/disease management. This needs to change.
- DMAP uses same system for OHP – health plans don't get reimbursed for services not valued by CMS.
- In 2009, CMS not allowing states to only tax Medicaid managed care health plans – this will remove the funding source for OHP-Standard.
- HIPAA impacts coordination of care. Barriers to coordinating care between OHP-contracted health plans, and dental care and mental health organizations. See work by Governor's Task Force on Health Information Security and Privacy (HISPC).
- Oregon needs to commit general funds to the Medicaid expansion population covered under OHP-Standard.

Fully Capitated Health Plan: Rhonda Busek, COO, Lane Individual Practice Association, Inc. (LIPA)

- *(See written testimony included under presentations.)*
- Medicaid system is complex, and difficult to streamline. Lack of timeliness of CMS approvals (on OHP waivers, etc.) put health plans in limbo.
- CMS should increase payments to Oregon providers (Medicare). Decreasing Medicare rates are problematic. OHSU is cutting slots.
- Concerned about CMS proposal to no longer use Medicaid funds for graduate medical education.
- All but one of the FCHPs are in Medicare too – there is a conflicting interpretation of rules between Medicaid and Medicare.
- New citizenship documentation requirements for enrolling in Medicaid (DRA 2005) mean that eligible citizens are denied enrollment and care. See DHS report on this *(NOTE: DHS report included in Feb 28 meeting materials).*
- OHP application process is tedious and long.

Fully Capitated Health Plans: Cindy Becker, Executive Director, Coalition for a Healthy Oregon

- No predictability for states, providers, clients under Medicaid. Clients must deal with eligibility changes, changes in services and covered benefits. Providers must deal with benefit coverage changes and payment changes.
- Medicaid fee structure limits access to care – doctors don't get paid enough, and there is no effort to recruit and retain doctors.
- Administrative burdens: FCHP contracts are 92 pages with 14 addenda.
- Treatment vs. prevention model: Get paid for treatment, not prevention or cognitive intervention. No incentive for doctors to do prevention especially with low rates.
- Cost-sharing/patient responsibility: Clients are inappropriately using the ER with no consequences. May be that they have no access to primary care, or they may just be used to going to the ER. EMTALA and Medicaid have limits on cost-sharing.
- Oregon's OHP rates of payments to health plans are actuarially set, then legislature cuts by some percentage (once 30%). These rates and cuts vary from year to year.
- Need to integrate health plans/MHOs/DCOs – currently have different structures. Need to remove barriers to coordination – real, perceived, territorial. Federal buckets of money set up this disjointedness.

- Long-term care: little integration with acute care. Medicaid spending on LTC will only increase as Oregon's older population increases – LTC will eat up Medicaid. Some go into LTC because they are not getting their acute care needs met.
- Can't change the delivery system without changing the payment system.

Discussion

- Question to panel: Are your provider networks stable? Rhonda Busek, LIPA – yes, because of a feeling of social responsibility. Pam Mariea-Nason, CareOregon – yes because they are part of the community, but often providers are not open to new members because they are looking at their payer mix. New members have a hard time finding providers. Cindy Becker, COHO – OHP-Standard population is now high needs, not appealing to doctors.
- Is it that prevention is not historically in the model, or are health plans prohibited from paying for prevention? If plans are fully integrated (own doctors) they could add it, but Oregon's FCHPs aren't structured this way. There are some CPT codes for prevention, but CMS won't pay for these.
- More efficiency in care means get paid less next year. Need a new system of accountability, not based on encounter data.
- Integrating public health approaches is paramount.
- Currently key word for providers is "production" – need to change from this way of thinking.

Dental Care Organizations (DCOs): Deborah Loy, OHP Services Director, Capitol Dental Care

- *(See written testimony included under presentations.)*
- In addition to representing Capitol Dental Care, Deborah is also representing two groups:
    - stakeholder group including all 7 DCOs, the Oregon Dental Association, public dental health, Hygiene Association, others;
    - A collaborative partnership between 4 of the DCOs.
- Importance of oral health as part of overall health.
- CMS has made adult dental services optional under Medicaid. Unpredictability of Medicaid coverage of adults has led to dentists dropping out of Medicaid.
- CMS prohibits dentists from dispensing "take home" products that reduce bacteria and remineralize the mouth.
- OHP-Standard only includes emergency extraction benefit – no other dental coverage.
- Medicaid case law prohibits billing for a service if also offered free to others at same time it is provided (e.g. onsite at school based health centers).
- Medicaid does not allow billing a no-show fee to the client. This is especially important for dentists who see patients for 60-90 minute appointments. Dentists cite OHP enrollees' high rate of no shows as a top reason for not wanting to participate in OHP.

Mental Health Organizations (MHOs): Jim Russell, Executive Manager, Mid-Valley Behavioral Care Network

- *(See written testimony and handouts included under presentations.)*

- Main federal challenges to mental health care in Oregon are regulatory CMS changes. *(Refers to DMAP report, pg. 26-27, 36 – see Exhibit Materials.)*
- CMS has been attempting to shift costs to states *(see APHSA/NASMD letter in his handout)* which will result in reduced access, lower quality of care, and fewer people with health coverage.
- CMS changes in the definition of case management - regulations are much more restrictive than intent of DRA. This regulation change was done by CMS as an Interim Final Rule (with no notice or comment period)
- New CMS requirements for cost reporting – no margin for working capital, risk reserves, carry-forward funds. All "unspent" dollars must be returned – resulting in increased admin costs and decreased services. (Congressional moratorium delays implementation until May 25, 2008)
- CMS changes in the definition of rehabilitation services - too restrictive (Congressional action has delayed implementation until June 30, 2008)
- CMS use of a capitation rate checklist - retrospective not prospective.

Discussion

- Suggestions for changing capitated rate measurements? Possibly change from encounter basis to some accountability measures, to reward innovation.

Chair Baumeister **IV. Follow-Up Mental Health Panel**

Community Mental Health Coalition of Oregon:

- **Angela Kimball, Director of State Policy, National Alliance on Mental Illness**
- **Leslie Ford, CEO, Cascadia**

- *(See presentation.)*
- High rates of mental health disorders (1 in 4 adults, 1 in 17 with serious mental illness, 1 in 10 children), yet low rates of care (1 in 3 adults with mental disorder access care).
- Screening and early intervention for youths and young adults are key. However, OHP and other insurance cuts off once youth become young adults.
- Stigma around mental illness – need for outreach, education, primary care integration.
- Adverse childhood experiences study (*see Exhibit Material for copy of study)* – links childhood trauma to health outcomes as adults.
- Persons with mental illness die younger than their peers of largely treatable medical conditions, need integrated health and mental health care.
- Need to align incentives to promote health – eligibility policies that promote continuity of care, financial incentives for prevention, screening, outreach, integrating health and mental health care.
- CMS does not require States' SCHIP programs to have mental health parity – requirement is coverage at 75% of medical care benefits, and need not cover evidence-based practices.
- Medicare has high copays for mental health care (50%) which are often uncollectible, leaving providers uncompensated. No parity around inpatient day limits. Case management, some evidence based treatments, some types of providers not covered.

- Medicare is hostile to mental health – many with mental illness are dual eligibles (in both Medicare/Medicaid). Medicare administrative costs are more than reimbursement covers.
- Medicare Part D issues. Medicare should restore coverage of Benzodiazepines, eliminate cost-sharing, raise income limits and asset tests to qualify for Low Income Subsidy, waive late enrollment penalty for subsidy, allow mid-year enrollment changes, and institute "intelligent assignment" for low-income beneficiaries into plans that more adequately cover their medications, provide 90-day enrollment periods for subsidy-eligible individuals.
- Medicaid issues: IMD exclusion means no Medicaid match for individuals aged 22-64 in institutes for mental disease with more than 16 beds.
- Medicaid limits billing to one service per day – restricts coordination of care.
- Medicaid proposed rules: Targeted Case Management, Treatment Foster Care, Rehab, and Case Management, threaten delivery of services to maintain health, coordination with other systems (e.g. education) and provide best practices
- Barriers related to Medicaid disability criteria, enrollment process, denial of benefits while incarcerated, moving from unemployed to employed.

(Digital recording stopped due to technical problem)

Chair Baumeister V. Medicaid Panel: Providers

Jane-Ellen Weidanz, Director of Public Policy, Oregon Association of Hospitals and Health Systems

- *(See presentation.)*
- (*Commenting on previous presentation)* CMS recently revoked IMD exclusion waivers in three states.
- Medicare and Medicaid together cover more than 30% Oregonians and drive Oregon health care by setting policy, funding, payment level, populations covered.
- Mindful of tension between Congress and the Executive – CMS makes policies that are inconsistent with Congress
- Medicare 24 month waiting period for people with disabilities once they become eligible for SSDI.
- Medicare Payment rates do not cover hospital's costs – on average, 81% of costs. Rate formula disadvantages cost effective states. Hospitals fare somewhat better under Medicare Advantage plans' rates.
- Efficiency in not the issue – Oregon is one of the most efficient states – there is very little efficiency left to be gained under Medicare.
- Medicaid: CMS approval of waivers – 2 year wait.
- Taxes (on Medicaid managed care and hospitals) that fund OHP standard sunset 9/09 due to federal law — Puts all OHP Standard at risk
- Medicaid Managed Care plans base hospital reimbursement on 80% of Medicare reimbursement and Medicaid FFS pays even less. So for every $1 in cost: Medicare = $.81 Reimbursement, Medicaid managed care = less than $.65 Reimbursement. Leads to huge uncompensated care costs ($751 million in 2006) for hospitals.
- Recommend Congress raise Medicare rates for efficient states like Oregon to the national average.

- Recommend CMS encourage states' efforts to expand coverage to uninsured. Would see flexibility – in waiver approval, flexibility to use different revenue sources, States using SCHIP to fullest extent, and consistent policies across states in waiver allowances.

Scott Gallant, Associate Executive Director, Oregon Medical Association

- *(See written testimony and handout included under presentations.)*
- Reform requires state-federal collaboration
- OMA supports US Sen. Ron Wyden's Health Americans Act, S 334.
- Support for Bruce Goldberg's recommendation at Jan 23 Federal Laws Committee meeting to broaden conversation with CMS. Medicaid is not a rational system, is overly regulated, wastes money adjusting to new rules/processing claims/submitting reports when there are no real benefits to these administrative costs.
- Medicare geographic payment variations – Oregon providers are paid less, results in access issues. These Medicare rates are used to calculate Medicaid rates – so Medicaid rates are low too.
- Federal anti-trust laws and Stark laws inhibit effective care and encourage oligopolies – leading to increased cost pressures.
- Federal support for medical education should be increased - workforce shortage-losing some federal support.
- Encourage Oregon Delegation to US Congress to develop and propose a long term strategy to develop access to services outside of hospitals – ideally clinics should offer 24 hour access for routine care.
- Permanently establish a rational rural health policy
- Revise federal tax structure to encourage individuals and small employers to purchase health insurance.
- Propose and adopt uniform standards for payment, quality measures and reduce overhead
- Implement interoperability standards before requiring quality measures, electronic prescribing and/or electronic medical records.
- Federally, at least, require all Americans will be protected from catastrophic medical costs.
- Oregon has been penalized for its efficient delivery system compared to other areas of the country – impacts physician services since Medicaid and some commercial payers follow Medicare payment policies.
- *(Refers to handout: "Physician Payments under OHP: Trends and Concerns" Henery & Assoc., June 2007 – see copy with presentation)* Study demonstrates Medicare underpays physicians and payments are projected to decrease. OHP payments, which are tied to Medicare rates, to physicians are low even though total dollars paid to hospitals have increased. Many physicians may drop OHP in the future.

Discussion

- Does Medicare Advantage pay better? Scott: Medicare Advantage FFS plans do not pass on substantial subsidies in their payments to physicians. Medicare Advantage managed care plans have 10-15% differential, but overall find 40% administrative costs are not reimbursed. Medicare Advantage rates are still based on traditional Medicare rates.
- Is primary care under-reimbursed? Scott: yes, but not sure that means that specialists are overpaid.

Chair Baumeister VI. Medicaid Panel: Safety Net Providers

Craig Hostetler, Executive Director, Oregon Primary Care Association

- *(See presentation.)*
- Federally Qualified Health Centers (FQHCs) background – will focus on Community Health Centers since Committee will discuss Indian Health at a separate meeting.
- Community Health Centers (CHCs) address more than just financial barriers (e.g. serving the uninsured) – they also address language barriers, transportation/geographic barriers, serve homeless, socially isolated, health literacy barriers, and persons with mental illness, substance abuse, cognitive impairment.
- Federal barrier: Medicare and Medicaid payment for primary care based on visits – this is flawed. Need to align payment for performance rather than cutting costs for effective performance.
- Community input should be expected into 1115 waiver development.
- Citizenship documentation barriers in Medicaid – requirements present financial/logistical barriers and raises uninsured level of CHC population
- Health Provider Shortage Area (HPSA) and Medically Underserved Areas/Populations (MUA & P) – federal definitions used to designate clinic as FQHC/Rural Health Clinic (RHCs) for federal funding. These definitions are outdated and don't favor the large counties of the west coast states. CMS proposed rules to roll definitions together which would result in far fewer areas designated as HPSA/MUA & P – reducing FQHC/RHC funds.

Discussion

- Would universal coverage adversely affect Safety Net Clinics? Would jeopardize grants based on % uninsured served, but Health Fund Board program to pay for these folks. However, Board should consider addressing other barriers/needs currently addressed by Safety Net Clinics – perhaps with enhanced reimbursement.

Scott Ekblad, Director, Office of Rural Health

- *(See presentation.)*
- Rural Health Clinics (RHCs) background – receive enhanced reimbursement from Medicare and Medicaid. Isolated Rural Health Clinics are sole source of primary care in their communities.
- RHC payment cap is based on baseline payment established in 1988 with annual increases based on Medicare Economic Index. Outdated.
- Mental health services only reimbursed by Medicare if provided by LCSW or clinical psychologists – should expand types of providers.
- Productivity guidelines for RHC staff determine payment for services but are outdated.

Discussion

- Comments on medical education/provider shortage? Area Health Education Centers Program at OHSU sends 3rd year medical students in a 5 week rotation in an Oregon rural clinic. National Health Services Corp scaled back its rural/underserved populations program.

Chair Baumeister VII. Public Testimony

No public testimony was offered.

Chair Baumeister VIII. Adjournment

Meeting adjourned by Chair Baumeister.

Submitted By:
Susan Otter

Reviewed By:
Chair Baumeister

EXHIBIT MATERIALS

1. Draft Agenda for Feb. 14 meeting
2. Summary of Jan. 23 Federal Laws Committee meeting presentations
3. DMAP Report to the Federal Laws Committee: "The impact of federal policy on Oregon's health care reform efforts: Opportunities and barriers within Medicaid and SCHIP"
   a. Summary of DMAP report
4. Data on Oregon's Uninsured
5. Oregon Health Care and Medicaid Spending
   a. Dollar amount spent determining eligibility for OHP
6. Background for presentations:
   a. List of FCHPs, MHOs, DCOs with enrollment
   b. "Safety Net Clinic/FQHC Overview" (OPCA 1/15 presentation to Board)
   c. "The Relationship of Adverse Childhood Experiences to Adult Health: Turning Gold into Lead," Vincent J. Felitti, MD, Kaiser Permanente Medical Care Program.
7. Follow-up information to 1/23 meeting:
   a. Formal definitions of "evidence based"
   b. US Congress press release, Jan 15, 2008: "Congressional Leaders Warn Against HHS Efforts to Limit Health Care for Low-Income Children"
   c. US Court of Appeals 9th Circuit Court decision on San Francisco ERISA case, Jan. 2008
8. Public comments/referrals from other Committees
   a. John Mullin (Oregon Law Center) comments to Federal Laws Committee
   b. Health Equities Committee recommendation referred to Federal Laws Committee
9. Other Committee business:
   a. Approved Federal Laws Committee Charter
   b. OHFB report to state legislature, "Health Insurance Exchanges and Market Reform," Feb. 2008
   c. February OHFB newsletter

PRESENTATIONS

1. Pam Mariea-Nason's testimony, CareOregon
2. Rhonda Busek's testimony, Lane Individual Practice Association (LIPA)
3. Deborah Loy's testimony, Capitol Dental Care
4. Jim Russell's testimony and handout, Mid-Valley Behavioral Care Network
5. Angela Kimball's presentation, National Alliance for Mental Illness
6. Scott Gallant's testimony and handout, Oregon Medical Association
7. Jane-ellen Weidanz's presentation, Oregon Association of Hospitals and Health Systems
8. Craig Hostetler's presentation, Oregon Primary Care Association
9. Scott Ekblad's presentation, Office of Rural Health

OREGON HEALTH FUND BOARD – Federal Laws Committee

January 23, 2008 **Pine Room, Willamette Education Service District,**
1:00pm (Digitally Recorded) **2600 Pringle Road SE, Salem, OR**

MEMBERS PRESENT: **Frank Baumeister, M.D., Chair**
Ellen Gradison, Vice Chair
Mike Bonetto (by phone)
Chris Bouneff
Michael Huntington, M.D.
Julie James (by phone)
Mallen Kear, R.N.
Cheryle Kennedy
Sharon Morris
Larry Mullins
Nicola Pinson
Thomas Reardon, M.D.

MEMBERS EXCUSED:

STAFF PRESENT: **Susan Otter, Policy Analyst**
Barney Speight, Executive Director, OHFB
Jeanene Smith, Administrator, OHPR
Erin Fair, University of Oregon Law Student, OHFB Intern
Judy Morrow, Assistant

ABSENT STAFF:

ISSUES HEARD:

- **Call to Order**
- **Approval of Agenda and November 29 Meeting Minutes**
- **Medicaid Panel: Consumer Advocates**
- **Medicaid Panel: Department of Human Services**
- **Medicaid Panel: County Mental Health Perspective**
- **Public Testimony**

(Digitally Recorded)

Chair Baumeister I. Call to Order

- There is a quorum.

Chair Baumeister II. Approval of Agenda and Nov. 29 Meeting Minutes

Motion to approve the minutes as written is seconded. **Motion passed unanimously.**

Discussion of item V. of November 29 minutes regarding July timeline set by legislature. Barney Speight will be asking the legislature to allow for a later date in order to meet the requirement for holding public hearings and coordinate work with that of other committees and have deadline moved to October.

Welcome to and introduction of Cheryle Kennedy, Council Chairwoman, The Confederated Tribes of Grand Ronde. It was noted that the minutes

list of Areas of Federal Policy to be considered (item V.) does not include Federally Qualified Health Centers (FQHC) used by some tribes and the Indian Health Services Act are not included. It will be added to the list.

Chair Baumeister **III. Medicaid Panel: Consumer Advocates**

Ellen Lowe, Advocate and Public Policy Consultant, Chair of the Eligibility and Enrollment Committee

- Different eligibility categories within Medicaid do not represent all in need, cause poor continuity of care.
- Discussed experiences with homeless and families in need, OHP Standard and FHIAP, and access to services issues.
- Suggested review of the Memorandum of Understanding with the Federal Government in the 1990's which included results-driven accountability and flexibility to respond to needs of Oregonians.
- Language of reform is not being understood by the community.
- Urged timelines to be liberally construed – important to take time to listen to Oregonians.

Kathryn Weit, Oregon Council on Developmental Disabilities, Member of the Benefits Committee

- Discussed the vulnerability of those with disabilities and warned about problems of only allowing "evidence-based" treatments.
- Federal Early Periodic Screening, Diagnosis, and Treatment (EPSDT) requirements are officially waived by the OHP – however, Oregon still requires these services but there is a perception these are not required.
- Oregon should take advantage of available Medicaid waivers.
- Would like to see waiver of current payment system and developing more cost effective ways to cover services.
- "Targeted case management" may not be covered by Medicaid soon.
- Problems with the developmentally disabled not receiving in-home services needed and having to live in nursing homes was recently addressed by the legislature.

Ellen Pinney (by phone), Oregon Health Action Campaign, Member of the Eligibility and Enrollment Committee

- Discussed experiences with Oregon Health Plan.
- Oregon should maximize federal money and flexibility
- Eligibility categories are confusing and arbitrary. *"We should separate health care from welfare."* Should be a right to insurance for all low income.
- Categories lead to breaks in coverage and barriers to staying on OHP – should have seamless enrollment.
- Should have uniform reimbursements and increased administrative simplicity.
- Medicaid & Medicare reimbursement rates limit access – limited number of Medicaid providers, doctors refuse to see patients once they turn 65.
- New & innovative ways of billing; payment for medical home model including web/phone consults.
- Take full advantage of federal (HRSA) 340b pricing for drugs.
- Oregon should be pooling various funding sources to make movement between groups seamless.
- Getting employers out of the healthcare financing business and allowing them to buy into Medicaid for employees.

- Should be a core set of benefits in both public and private markets.
- Importance of streamlining application process.

Chair Baumeister **IV. Medicaid Panel: Department of Human Services**
Bruce Goldberg, Director, DHS

- Federal health care policy is unintelligible and contradictory: Medicaid tries to keep people out with limited enrollment and categories, but includes long-term care. Medicare presumes all are eligible by age, but does not include long-term care unless you become impoverished first. It is a *"bureaucratic nightmare"* – waivers take 1-2 years for approval.
- Urged against thinking about waivers and exclusions – instead consider a politically strategy.
- Strategy should include how to create an innovative system that will streamline care. Currently have different payment rates and quality initiatives between Medicaid, Medicare, and private markets. Issues with portability.
- Strategy – Oregon should engage in conversations with federal programs to create a shared vision to help Oregon provide the best care, quality, access, affordability, while accepting fiscal responsibility.
- Short-term – we should look to maximizing Medicaid dollars and long-term – more complex, global aspirations.
- Medicaid is 10% of the money & 90% of the regulations while Medicare has fewer of the regulations.
- DHS is in the process of simplifying OHP application process

Discussion

- Discussion on different poverty levels for different populations and their needs.
- Could an employer that provides no coverage puts some employer dollars on the table along with the employee's contribution.
- Amount of money spent on determination of eligibility.
- Integrating programs and mental health.

Jim Edge, Assistant DHS Director, Division of Medical Assistance Programs.

- Eligibility: In general, federal government will accept adults up to 200% of FPL and children up to 250% of FPL. These guidelines are less flexible today than in the past, may become more flexible with new administration.
- Oregon uses prioritized list, which lets us cover what makes sense.
- About 2% of Medicaid costs are for administrative costs. DMAP is working on simplifying eligibility process.
- Most OHP enrollees are covered by managed care, where payments are capitated. FFS payments are lower.
- Difficult to maximize federal Medicaid money – Oregon has some contacts at CMS to help with innovative ideas. There will be some opportunity with the new administration.
- FHIAP must have equivalent level of benefits as OHP, but all FHIAP plans include cost-sharing.
- Requirement by Federal programs for cost neutrality – Oregon has consistently been under budget ceiling for neutrality.
- CMS is much less flexible on benefits to categorically eligible populations and more flexible with the expansion population.

- ***NOTE: DMAP provided the Federal Laws Committee with a detailed report on opportunities and barriers within Medicaid and SCHIP. This report (along with a summary) was included in the exhibit materials for the Feb 14 meeting.***

Chair Baumeister **V. Medicaid Panel: County Mental Health Perspective**
Sharon Guidera, Mental Health Director, Mid-Columbia (Hood River, Sherman, Gilliam, Wasco Counties)

- Provided input from the service delivery level.
- Focused comments on 1) administrative overhead; 2) clinical fit of Medicaid and some of the challenges; and 3) other best practice and evidence based models in terms of delivery of behavioral healthcare.
- Spoke regarding experience as chair of the local implementation committee for the Committees of the Governor's Steering force for Services to Children and Families called the Oregon Children's Wraparound Initiative.
    - What families want is a person-centered medical home, comprehensive services, predictability and electronic records.
- Showed that her agency's contract with a Fully-Capitated Health Plan for addiction services is short (several pages) and the contract with a mental health organization (MHO) is long (several inches thick), and information does not transfer between the two.
- Medicaid is very prescriptive when it comes to billing.
- Regarding administrative overhead and requirements: worry that *"we treat paper, not people".* Can't bill for behavioral health care provided at the same time as physical health care.
- Case management function, a covered service, coordinates available programs to help families navigate through the system, but is not funded through mental health.
- Do not have psychiatric beds in the counties she works with. Instead, they are sent to ERs and jails. Problems with staff quitting because of this plus these facilities are not prepared to cope with mental health. Costs of mental health to other institutions.
- Need regional level access, but warned that if only mental health hospital beds are added will be filled and will be back in the same situation. Need more psychiatrists and psychiatric care.

Chair **VI. Public Testimony**
No public testimony was offered.

Chair **VII. Adjournment**
Meeting adjourned by Chair Baumeister.

Submitted By:
Paula Hird

Reviewed By:
Susan Otter

EXHIBIT MATERIALS

1. Agenda
2. Meeting Minutes from 11/29/07
3. Schedule of 2008 Federal Laws Committee Meetings
4. Primers on Medicaid/SCHIP, OHP, FHIAP:
    a. Excerpt from CMS Publication "Medicaid-at-a-Glance 2005"
    b. DMAP Primer of Medicaid/SCHIP in Oregon for Ways and Means Presentation
    c. FHIAP Overview for OHFB, January 2008
    d. Excerpt from FHIAP Snapshot of Program Activity, January 7, 2008
5. Families USA FAQ's about Medicaid Waivers

6. Oregon's Medicaid Waiver:
   a. KFF brief on Oregon's 1115 waiver
   b. OHP coverage chart and OHP variation in federal match 1998-2010
   c. Current OHP Expansion terms and condition
7. Reform Efforts in Other States:
   a. Current State Expansion Plans and Proposals, December 2007
   b. Overview of Western States' Reform Proposals January 2008
8. Goals of the Health Fund Board Committees
9. OHFB January Newsletter
10. "Achieving a High Performance Health Care System with Universal Access: What the United State can Learn from Other Countries," Position Paper of the American College of Physicians, Annals of Internal Medicine, January 1, 2008. Vol. 148, No.1
11. "Learning from the Health Care Systems of Other Countries," Harold C. Sox, MD, Editor. Annals Of Internal Medicine, January 1, 2008, Vol. 148, No.1
12. Market Justice and US Health Care." JAMA, January 2, 2008. Vol. 299, No. 1
13. OPCA Letter to Federal Laws Committee

OREGON HEALTH FUND BOARD – Federal Laws Committee

November 29, 2007 **CCC, Wilsonville Training Center, Room 112**
9:30am (Digitally Recorded) **Wilsonville, OR**

MEMBERS PRESENT: **Mike Bonetto**
Thomas Reardon, M.D.,
Mallen Kear, R.N.
Ellen Gradison
Frank Baumeister, M.D.
Nicola Pinson
Sharon Morris
Michael Huntington, M.D.
Chris Bouneff (by phone)
Julie James (by phone)

MEMBERS EXCUSED: **Larry Mullins**

STAFF PRESENT: **Susan Otter, Policy Analyst**
Barney Speight, Executive Director, OHFB
Erin Fair, University of Oregon Law Student, OHFB Intern
Jeanene Smith, OHPR Administrator
Tami Breitenstein, Executive Assistant

ABSENT STAFF: **Judy Morrow, Assistant**

ISSUES HEARD:

- **Call to Order, Committee Members and Staff Introductions**
- **Review of Bylaws**
- **Introduction to Senate Bill 329 Reform Process and Assumptions for Reform**
- **Review of Draft Committee Charter, Timeline and Proposed Strategy**
- **Nominations and Elections of Committee Chair and Vice Chair**
- **Public Testimony**

(Digitally Recorded)

Susan Otter **I. Call to Order of the First Meeting of the Federal Laws Committee –**
- There is a quorum.

Susan Otter **II. Introduction of Committee Members, Staff and Public Attendees**

Susan Otter **III. Exhibits Overviewed and Review of Bylaws**
- Overview of exhibits
- Review of Bylaws highlighting:
    - Any changes to bylaws may be made only by the Oregon Health Fund Board (OHFB);

- Public Meetings Laws, including:
  - Substantive discussions cannot be conducted through emails;
  - Meetings without a quorum do not need to be open to the public, although we may choose to make them open meetings.

Barney Speight **IV. Introduction to SB 329 Reform Process and Assumptions for Reform**

- Reviewed the Governor's appointments to the Oregon Health Fund Board (OHFB) per SB 329 and the Board's actions to date. OHFB will meet monthly, and anticipates meeting twice monthly in May and June.
- Described six committees. The chair of each committee serves as an ex-officio, non-voting member, and a full participant in the deliberations of the Board. Committees are being tasked by the OHFB through charters to be finalized in December and January.
- Described timeline. Deliverables are due to Governor and Legislative leadership by October 1, 2008. Draft recommendations from committees should be in framework by end of April. Board will draft a plan in May/early June for presentation to public for comment. Public comment is to be reviewed by the Board after Labor Day of 2008 and a final report will be prepared including formal recommendations. In January 2009, the focus of reform moves to legislature.
- Discussed the Board's draft document: A Comprehensive Plan for Reform: Design Principles and Assumptions.

Barney Speight **V. Review of Federal Laws Committee Charter, Timeline and Proposed Strategies**

- Review of charter: SB 329 mandates Committee to examine federal laws that result in barriers to Oregon health care reform. Areas identified in law and by staff include:
  - Medicaid requirements;
  - Medicare policies including, reimbursement and effects on costs, quality, and access;
  - Federal Tax Code policies;
  - Emergency Medical Treatment and Active Labor Act (EMTALA) regulations and waivers;
  - Health Insurance Portability and Accountability Act (HIPAA);
  - Employment Retirement Income Security Act (ERISA); and
  - Any other areas of federal policy that inhibit Oregon's reform efforts.

Discussion

- Areas of federal policy to include:
  - Include State Children's Health Insurance Program (SCHIP) and Family Health Insurance Assistance Program (FHIAP) in Medicaid discussion.
  - Include Medicare Advantage plans in Medicare discussion, especially as Oregon has the highest Medicare Advantage penetration in the nation.
  - Shortage in workforce problem – Committee could address federal/state policies on reimbursement for health professionals' education.

- Include Federally Qualified Health Centers (FQHC) under Medicaid law and the Public Health Service Act as part of Oregon's health safety net system.
- HIPAA discussion: HIPAA may impede coordination of mental and physical health care. One resource: Oregon's Health Information Security and Privacy Collaborative (HISPC) looking at issues related to privacy and security. 42CFR and HIPAA deal with behavioral health privacy, including addiction treatment.

- Review proposed strategy and timeline: Barney presented the proposed strategy and draft letter seeking stakeholder input. The proposal is to gather findings and develop ideas for recommendations by soliciting written and in-person public input. This would include holding meetings on specific subjects to include panel discussions from a range of stakeholders. Discussion:
  - We should ask stakeholders to propose solutions;
  - Staff should provide an overview of the federal authority for making changes (e.g., waivers, policy/regulatory changes, acts of congress).
  - Staff should provide background information including reform efforts in other States (Anne Gauthier's presentation to the Board), Kaiser report on federal/state partnership, and John McConnell's presentation to the Board.
  - The Committee verbally endorsed the proposed strategy.
- Committee members should contact staff to identify additional stakeholders to send solicitation letter, and to relate thoughts on issues and approaches. Members are welcome to email the board at ohfb.info@state.or.us.

Barney Speight **VI. Nominations and Election of Chair and Vice Chair**

- The Committee unanimously elected Dr. Frank Baumeister as Chair and Ellen Gradison as Vice Chair.
- Gavel was passed to Dr. Frank Baumeister for remainder of meeting.

Chair **VII. Future Meetings**

- Discussion of scheduling January meeting, meeting locations and times.
- Next meeting will be scheduled for the week of January 21, 2008.

Chair **VIII. Public Testimony**

- Liz Baxter, Executive Director of the Archimedes Movement, urges openness to all recommendations, even if not reasonable, as it may *"change level of debate"* and to include consumers in panels. Glad Committee will make recommendations and not just report findings.
- Scott Gallant, Oregon Medical Association, testifies regarding surveying providers and offers assistance to Committee.
- Jane Ellen Weidanz, Director of Public Policy for Oregon Association of Hospitals and Health Systems, urged the Committee to look at federal laws regarding publicly funded services for the mentally ill, specifically through Substance Abuse and Mental Health Services Administration (SAMSHA) funds, as well as federal laws that may not promote healthy lifestyles. She also offers assistance to the Committee.
- Beryl Fletcher, Director of Professional Affairs of the Oregon Dental Association, asks Committee to also focus on oral health care and periodontal issues considering their links to overall health.

- Jerry Cohen, State Director of AARP for Oregon, supports involving AARP members, and asks Committee to include issues around coordination of Medicare and Medicaid policies as well as coordination of long-term care and chronic care.
- Committee Member Tom Reardon recommends attending the health system change presentation by Dr. Paul Ginsberg, Health Economist, in mid-December.

Chair **IX. Adjournment**

Meeting adjourned by Chair Baumeister.

Submitted By:
Paula Hird

Reviewed By:
Susan Otter

EXHIBIT SUMMARY

1. OHFB Committee Members List
2. OHFB Organizational Documents: Overview Timeline and Duties from SB 329
3. SB 329 & SB 329Summary
4. Oregon Business Council Policy Playbook*
5. Description of OHPR Programs
6. Draft Charter of the Federal Laws Committee
7. Federal Laws Committee By-laws
8. OHFB Design Principles & Assumptions
9. OHFB Timeline
10. Draft Stakeholder Solicitation Letter
11. Citizen's Health Care Workgroup Report: Executive Summary (Will be given as a handout to board members and will be available at http://citizenhealthcare.gov for the general public.)

*Available at: http://www.oregonbusinessplan.org/pdf/OBP%20POLICY%20PLAYBOOK%202.5%20_FINAL_.pdf